

PENNSYLVANIA RESIDENTS SURETY BOND

SURETY BOND NO. \_\_\_\_\_

KNOW ALL MEN BY THESE PRESENTS,

That we, \_\_\_\_\_,

Principal and \_\_\_\_\_, as  
company organized under the laws of the State of \_\_\_\_\_, and licensed  
to do business in the Commonwealth Of Pennsylvania, a Surety, are held and firmly bound unto the  
Residents of \_\_\_\_\_, as Obligees, in  
(Name of Facility)

the total penal sum of \_\_\_\_\_ Dollars  
(\$ \_\_\_\_\_) lawful money of the United States of America, for which sum well and truly to  
be paid said Principal and Surety bind themselves, their heirs, executors, administrators, successors  
and assigns, jointly and severally firmly by these presents.

WHEREAS, the above named Principal Is, or Is the operator of, a skilled nursing facility, an  
intermediate care facility or a nursing facility as defined by Section 483.5 of the Health Care  
Financing Administration, Health and Human Services Code of Federal Regulations. The Provision at  
42 CFP 483.10 (c) (7) requires each licensee or licensee-applicant to post a surety bond, in an  
amount equal to the average balance of residents' funds held by such licensee or licensee-applicant  
during the previous year, conditioned as set forth herein below:

NOW, THEREFORE, the condition of this obligation is such that if the above named Principal shall:  
(1) well and truly hold separately and in trust all residents' funds deposited with Principal as, or as the  
operator of, a skilled nursing facility, an intermediate care facility or a nursing facility, and (2) shall  
administer said funds on behalf of said residents in the manner directed by the depositors thereof, and  
(3) shall render true and complete accounts to the residents, the depositors and the Obligees when  
requested; and (4) upon termination of each said deposit, shall account for all funds received  
thereunder, expended and held on hand, then this obligation shall be null and void, otherwise to  
remain in full force and effect.

PROVIDED, this bond is executed and accepted subject to the following conditions:

1. The Department of Health, and with its written consent, any aggrieved resident or depositor, may maintain in his own name, an action on this bond, to recover for Principal's alleged breaches of the condition hereof, in any Court of competent jurisdiction in the Commonwealth of Pennsylvania.
2. Regardless of the number of years, this bond shall continue in force and the number of premiums which shall be payable or paid, the limit of Surety's liability hereunder, as specified herein or in any amendatory rider made a part hereof, shall not be cumulative from year to year, period to period or license to license.

3. The liability of the Surety hereunder shall never exceed the amount of the total sum of this bond, regardless of the number of claimants hereunder, and when Surety shall have Paid that amount, whether in one payment or the aggregate of several payments for, won or by reason of one or several breaches of the Condition hereof, the liability of Surety shall immediately cease and determine.
4. This bond shall apply only to residents funds hold by said Principal on, or at any time after, the effective date hereof, and before the effective date of termination hereof, as hereinafter provided.
5. This bond shall be effective as of 12:01 a.m. on \_\_\_\_\_ and shall expire on \_\_\_\_\_, but may be continued by Continuation Certificate signed by the Principal and Surety.

IN WITNESS WHEREOF the parties hereto have hereunto affixed their hands and seals this \_\_\_\_\_ day of \_\_\_\_\_

Principal: \_\_\_\_\_

By: \_\_\_\_\_

Surety: \_\_\_\_\_

By: \_\_\_\_\_

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## SURETY BOND APPLICATION

AGENCY NAME: \_\_\_\_\_ AGENCY CONTACT \_\_\_\_\_  
 AGENCY PHONE: \_\_\_\_\_ AGENCY FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_  
 AGENCY ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

**CURRENT OR EXPIRING QUOTE WE ARE LOOKING TO BEAT?** \_\_\_\_\_  
**NAME OF PREVIOUS SURETY COMPANY WRITING THE BOND?** \_\_\_\_\_

**SECTION I: BOND APPLIED FOR:**

TYPE OF BOND: \_\_\_\_\_ AMOUNT: \_\_\_\_\_  
 OBLIGEE: \_\_\_\_\_ EFF. DATE: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_  
 OBLIGEE ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)  
 BUSINESS NAME: \_\_\_\_\_  
 BUSINESS PHONE: \_\_\_\_\_ BUSINESS FAX: \_\_\_\_\_ Client E-mail \_\_\_\_\_  
 BUSINESS ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)  
 TYPE OF COMPANY CORP  LLC  DBA  PARTNERSHIP  HOW MANY OWNERS? \_\_\_\_\_

DATE BUSINESS ESTABLISHED: \_\_\_\_\_ BUSINESS TAX ID: \_\_\_\_\_  
 HAS ANY COMPANY REFUSED TO ISSUE BONDS FOR ANY PURPOSE? YES  NO  DO YOU HAVE ANY LIENS, CLAIMS, OR JUDGEMENTS AGAINST YOU? YES  NO   
 HAS APPLICANT EVER FAILED IN BUSINESS? YES  NO  HAS APPLICANT EVER FILED BANKRUPTCY? YES  NO

**SECTION II: GENERAL INFORMATION**

OWNER'S NAME: \_\_\_\_\_ SPOUSE NAME \_\_\_\_\_  
 SS#: \_\_\_\_\_ SPOUSE SS# \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 RESIDENTIAL ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)  
 ADDITIONAL OWNERS / PARTNERS  
 OWNER'S NAME: \_\_\_\_\_ SPOUSE NAME \_\_\_\_\_  
 SS#: \_\_\_\_\_ SPOUSE SS# \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 RESIDENTIAL ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

**PERSONAL FINANCIAL STATEMENT OF ASSETS & LIABILITIES AS OF \_\_\_\_\_**

ASSETS		LIABILITIES	
CASH IN BANK	\$	NOTES PAYABLE TO BANKS	\$
CASH ON HAND	\$	NOTES PAYABLE TO OTHERS	\$
STOCKS & BONDS	\$	ACCOUNTS PAYABLE	\$
ACCOUNTS RECEIVABLE	\$	FEDERAL & STATE INCOME TAX DUE	\$
NOTES RECEIVABLE	\$	ALL OTHER TAXES	\$
INVENTORY	\$	ACCRUALS, PAYROLLS, ETC.	\$
CASH VALUE OF LIFE INSURANCE	\$	DUE ON EQUIPMENT	\$
EQUIPMENT	\$	DUE ON REAL ESTATE	\$
REAL ESTATE	\$	OTHER LIABILITIES	\$
OTHER ASSETS	\$	CAPITAL STOCK (IF A CORPORATION)	\$
		SURPLUS & UNDIVIDED PROFITS	\$
<b>TOTAL ASSETS</b>	<b>\$</b>	<b>TOTAL LIABILITIES</b>	<b>\$</b>
		<b>NET WORTH</b>	<b>\$</b>
<b>NAME OF OWNERS</b>	<b>NAME &amp; TITLE OF OFFICERS</b>	<b>PERCENTAGE OF OWNERSHIP</b>	

Completion of this form constitutes permission for worldwide insurance specialists inc. to obtain consumer information which will be used to determine bonding eligibility.

<b>Worldwide Insurance Specialists, Inc</b> <b>2424 W. Missouri AVE</b> <b>Phoenix, AZ 85015</b> <b>E-Mail SAM@WWISINC.COM</b>	<b>Toll Free: (888) 518-8011</b> <b>Local (602) 749-0702</b> <b>Fax: (602) 674-8235</b>
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