APPLICATION – ADULT DAY CARE

BUSINESS INFORMATION

1. Named Insured ______________________________

2. Mailing Address ______________________________

3. Location(s) of premises: ☐ Same as mailing address ☐ Other ______________________________

4. Telephone # ____________________ Fax # ____________________

5. Contact Person/Phone # Inspection ____________________ Accounting/Records ____________________

6. Business Type:
   - ☐ Individual ☐ Partnership ☐ Corporation
   - ☐ Limited Liability Company ☐ Trust
   - ☐ Other: ______________________________

7. Operating As:
   - ☐ Profit ☐ Nonprofit
   - ☐ Other: ______________________________

8. Interest of Named Insured in Premises:
   - ☐ Owner ☐ General Lessee ☐ Tenant
   - ☐ Other: ______________________________

9. Part Occupied by Named Insured:
   - ☐ Entire ☐ Portion _____%
   - ☐ Other (Lessor's Risk Only): ______________________________

10. Date Business Established: ______________________________

DESIRED TERMS AND CONDITIONS

1. Coverage Desired:
   - ☐ General Liability ☐ Professional Liability

2. Limit of Liability Desired:
   - ☐ $1000,000/$300,000 ☐ $300,000/$600,000
   - ☐ $500,000/$1,000,000 ☐ $1,000,000/$1,000,000
   - ☐ Other: ______________________________

Note: Standard coverage includes the following:

Damage to Premises Rented to You	$100,000
Medical Payments	$5000
Personal and Advertising Injury	Same as Occurrence Limit

3. Contractual Liability: ☐ (Attach copy of contract) No separate limit

4. Effective Date Desired ________ Term Desired ________

TYPE OF FIRM

1. Type of day care:
   - ☐ Social – provides non-medical care to adults in need of personal care services only
   - ☐ Health(may include Social – provide health, social, rehabilitative and mental health needs)
   - ☐ Other

2. Description of operations. ________

PREMISES

1. Age of building ____
2. Construction ____
3. Number of floors ____
4. Total square footage ____
5. Central station alarm ☐ Yes ☐ No
6. Emergency lighting ☐ Yes ☐ No
7. Full sprinkler system? ☐ Yes ☐ No

   If no, describe extent of sprinkler system.

   ____

   ____

8. Last update: Wiring ________ Plumbing ________

9. Smoke detectors in : All rooms ☐ Yes ☐ No
   Halls ☐ Yes ☐ No
10. Are there any swimming pools? ☐ Yes ☐ No
11. Has emergency evacuation plan been prepared? ☐ Yes ☐ No
12. Are both scheduled and unscheduled fire and emergency drills conducted? ☐ Yes ☐ No
13. Are emergency facilities readily available? ☐ Yes ☐ No
    If yes, describe ________

    ____

OPERATIONS

1. Does your facility provide: Physical therapy ☐ Yes ☐ No
   Medication services ☐ Yes ☐ No

2. Describe all services and activities provided. Attach any brochures or other advertising material used by the facility.

   ____

   ____

3. Number of participants: Social Care ____ Health Care ____

4. Participant age groups (#for each): Under 18 Years ____ 18-65 Years ____ Over 65 Years ____

5. Are there procedures in place for participant screening and acceptance? ☐ Yes ☐ No

6. Are current records and files maintained on each participant? ☐ Yes ☐ No

7. Have any participants been diagnosed with Alzheimer's? ☐ Yes ☐ No
   If yes, how many at the following states:
   Stage 1 ________ All other stages ________

8. Have any participants been diagnosed with a mental illness? ☐ Yes ☐ No

9. Number of participants not capable of taking action for self preservation ______
   Number of participants capable of taking action for self-preservation ______

10. Any non-ambulatory patients above the second floor ☐ Yes ☐ No

11. Is there a record keeping system in place that documents:
    Operational procedures ☐ Yes ☐ No
    Incidents ☐ Yes ☐ No

12. Describe duties of volunteers or students.

    ____

    ____

13. Additional insureds state their interests in insured's operation.

    ____

    ____

14. Total all locations: Receipts $___________

15. How are funds obtained? (i.e. Medicare, donations, fees, government grant, etc.)

    ____

    ____

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? ☐ Yes ☐ No

2.

Staff	Total Number	Staff	Total Number
Nurse Practitioners	_____	Recreational Therapists	_____
RN/LPN/LVNs	_____	Social Workers	_____
Psychologists	_____	Aides/Homemakers	_____
Physical Therapists	_____	Counselors	_____
Occupational Therapists	_____	Other (define)	_____

   a. Are all staff certified/licensed according to federal ,state, or local requirements? ☐ Yes ☐ No
   b. Is any staff working on a contract basis? ☐ Yes ☐ No
      If yes, do you require proof of separate professional liability insurance? ☐ Yes ☐ No

3. Check all procedures you use when hiring professional, paraprofessional, or any other employees providing patient care services at your facility:
   a. Educational background or residency program check, when applicable ☐ None ☐ Written ☐ Verbal
   b. Previous employers check ☐ None ☐ Written ☐ Verbal
   c. Personal reference check ☐ None ☐ Written ☐ Verbal
   d. Verify any pending license suspensions or revocations or any pending disciplinary action by other facilities or any professional liability or work-related claim that has previously been made against any individuals ☐ None ☐ Written ☐ Verbal
   e. Criminal back ground check ☐ None ☐ Written ☐ Verbal
      Are copies of background checks kept on file ☐ Yes ☐ No

EDUCATION, LICENSING, ACCREDITATION

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility? ☐ None ☐ Written ☐ No licensing requirements
   If no state reasons for non-compliance and corrective action taken.

   ___

   ___

   Have you had any licensing or code violations in the past three years? ☐ Yes ☐ No
   If yes, describe.

   ___

   ___

   Does state licensing differentiate participant's ability for self preservation in the event of an emergency? ☐ Yes ☐ No

2. Is the facility accredited by any governmental or other body? ☐ Yes ☐ No
   If yes, describe.

   ___

   ___

3. Are you a member of any professional association or organization? ☐ Yes ☐ No
   Name of association or organization

   ___

RISK MANAGEMENT

1. Do you have a formal written risk management program? ☐ Yes ☐ No
   If no, how are these duties delegated?

   ___

   ___

2. Do you have a written requirement that health care professionals providing services at your facility(ies) carry Professional liability insurance and provide proof of this coverage? ☐ Yes ☐ No

3. Do you have:
   a. Written job descriptions ☐ Yes ☐ No
   b. Manual Policies and/or procedures ☐ Yes ☐ No
   c. Full-time administrator or medical director staff ☐ Yes ☐ No
   d. Formalized loss control and claim prevention training programs ☐ Yes ☐ No
   e. Emergency shelter arrangements for participants ☐ Yes ☐ No

4. Have you entered into any other contractual agreements? ☐ Yes ☐ No
   a. If yes, is legal advice sought to write and approve? ☐ Yes ☐ No
   b. Does the agreement require you to hold any third party harmless? ☐ Yes ☐ No

PREVIOUS EXPERIENCE

1. Describe management's/administrator's education and experience

   ___

2. Have you or any partner, officer, director, or employee ever been the subject o f disciplinary action by a regulatory authority as a result of his / her professional activities? ☐ Yes ☐ No
   If yes, explain:

3. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION** Has insurance of this type been canceled, refused, or non-renewed by any company during the past three years?	☐ Yes	☐ No

If yes, give name of company, date and reason: ____________________

PRIOR CARIER INFORMATION FOR THE PAST THREE YEARS					
Year	**Carrier**	**Policy Number**	**Coverage**	**Check if Claims-Made**	**Premium**

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant ____________________ Title ____________________ Date ____________________

Signature of Producing Agent ____________________ Date ____________________

Agent Name ____________________ Agent Address ____________________