



**Healthcare/Miscellaneous Facilities Liability
Application for Adult Day Care Centers**

SECTION A. APPLICANT

1. Legal name of the parent entity to be the first named insured exactly as it shall be shown on the policy.

First Named Insured	Street Address
City, State, Zip Code	County

2. Please indicate if there have been any changes in operations, management, ownership, exposures, locations, or services provided in the past 12 months. Yes No
If Yes, describe: _____

3. Coverage Period Requested From: To: __
Date Renewal Quotation Desired:

SECTION B. EXPOSURES

- Are you licensed by the State? Yes No N/A
 - License Number: Expiration date of License: License Capacity:
 - Has license ever been revoked or suspended? Yes, Explain: _____ No
 - Professional or Trade Organization?
- Indicate type of Facility: Social Medical/ Mental
Describe: _____
- This adult day care is located in which type of building?
Commercial Church School Private home (**Not Eligible**) Other (describe):
- The neighborhood is primarily:
Commercial / Industrial Residential Urban/City Country / Farming
- Type of Day Care:** **% of services**

Type I: Adult social care provides social care and social activities such as meal, recreation and some basic health-related services such as having a nurse on staff to check pressure _____
(Light exposures)

Type II: Adult day health care offers more intensive health, therapeutic, and social services for individuals with moderate to severe medical and cognitive problems including an incidental exposure (up to 25%) of clients with Alzheimer's. Activities within this category also include social activities for clients that require more intense health, therapeutic and medical care (moderate to heavy exposures) _____

Type III: Alzheimer's specific adult day care provides social and health services to persons with Alzheimer's or related dementia. The predominant exposures in this category are _____
clients with this diagnosis or organizations that have an Alzheimer's or related dementia exposure greater than an incidental as outlined with in Type II description.
For Type II and Type III, Please outline the types of medical services provided: _____
- What is maximum number of clients on premises at one time?
 - Average daily attendance?
 - Hours of Operation: ; Days of Operation:
- Please describe all the activities at this facility:

Clientele:

18 to 35 years: %	36 to 50 years: %	51 to 65 years: %	Over 65 years: %
-------------------	-------------------	-------------------	------------------

- How many Non-ambulatory clients are there?
 - On what floors are the Non-ambulatory patients?
8. What Precautions are taken to keep track of Clients? _____

Asst/Homemaker						
Dietician/Nutritionist	—	—	—	—	—	—
Mental Health Counselor	—	—	—	—	—	—
Nurse/R.N./L.P.N.	—	—	—	—	—	—
Occupational Therapist	—	—	—	—	—	—
Pastoral Counselor	—	—	—	—	—	—
Physical Therapist	—	—	—	—	—	—
Psychologist	—	—	—	—	—	—
Rehabilitation Counselor/ Therapist	—	—	—	—	—	—
Respiratory Therapist	—	—	—	—	—	—
Social Worker	—	—	—	—	—	—
Speech Therapist	—	—	—	—	—	—
Technicians	—	—	—	—	—	—
Other (specify) _____	—	—	—	—	—	—
Other (specify) _____	—	—	—	—	—	—
GRAND TOTAL:	—	—	—	—	—	—

These independent contractors will not be insureds and will not have coverage under the policy for which the applicants are applying. Such independent contractors should obtain their own insurance. FTE means Full Time Equivalents. 1 Full Time Equivalent = 2,000 annual hours.

1. Provide Staff - to – Client Ratio:
2. Are employees screened to rule out drug, alcohol and sexual abuse? Yes No
3. Check all methods used in hiring all employees or independent contractors:
Drug Testing Criminal Background checks – Federal State County Reference Checks
Personal Interview Sexual Abuse Registry Validate Driver’s License Validate Work History
Validate Education Verify Certification / Professional License Verify Personal Auto Insurance Limits
4. How are references checked: Written Verbal Both
5. Are all of the above methods done prior to hiring? Yes No
6. Do you require Certificates of Insurance from all contracted professional (not employees)? Yes No
7. Do you have volunteers on site? Yes No N/A
a. If so, how many What are their responsibilities? _____
8. Do you have incident reporting procedures and / or committee reviews? Yes No
9. Do you have a plan for medical emergencies? Yes No
10. Is there always someone trained in CPR and first aid on premise? Yes No
11. Do you have an Automatic External Defibrillator(s)? Yes No
Are Staff members trained to use it? Yes No
12. Do you have a written and enforced no smoking policy? Yes No
13. Are “no smoking” signs posted in all areas not designated for smoking Yes No

SECTION D. COVERAGE REQUESTED

1. Coverage/Limits/Deductible Requested – Healthcare Facilities Professional Liability:

Claims-Made Only Retroactive Date:	Limit of Liability Requested: \$1,000,000 Each Professional Incident \$3,000,000 Aggregate Other:
Is any applicant currently enrolled in a Patient Compensation Fund? Yes No If Yes, in what state(s) and for what limits: State(s) Limits \$ Each Professional Incident \$ Aggregate	Deductible (Each Professional Incident/Aggregate): \$5,000/None \$10,000/None \$15,000/None Other: \$ _____

2. Coverage/Limits/Deductible Requested – General Liability

Occurrence Claims-Made If Claims-Made, Retroactive Date:	Limit of Liability Requested: \$1,000,000 Each Occurrence \$3,000,000 Aggregate Other: \$ _____
Deductible (Each Occurrence/Aggregate): \$10,000/None \$25,000/None \$50,000/None Other: \$ _____	

3. Underlying Coverage/Limits Requested – Excess Liability:

Deductible (Each Occurrence/Aggregate):
 \$10,000/None \$25,000/None \$50,000/None Other: \$ _____

3. Underlying Coverages/Limits Requested – Excess Liability

Underlying coverages: Healthcare Facilities Professional Liability Retroactive Date: General Liability If Claims-Made, Retroactive Date: Other: _____	Excess Limits of Liability Requested: \$1,000,000 Each Occurrence or Each Professional Incident \$1,000,000 Aggregate \$2,000,000 Each Occurrence or Each Professional Incident \$2,000,000 Aggregate \$3,000,000 Each Occurrence or Each Professional Incident \$3,000,000 Aggregate \$4,000,000 Each Occurrence or Each Professional Incident \$4,000,000 Aggregate \$5,000,000 Each Occurrence or Each Professional Incident \$5,000,000 Aggregate Other: \$ _____
---	--

SECTION E. PRIOR ACTS WARRANTY

- If this application is for new Claims-Made coverage including prior acts with Chubb, will all current Primary and Excess Claims-Made policies accept claims for (a) a written notice, demand or service of suit against any applicant, and (b) specific circumstances reasonably likely to give rise to a written notice, demand or service of suit against any applicant? Yes No
 If Yes, does the applicant have a process to identify claims and specific circumstances regarding loss events reasonably likely to give rise to a written notice, demand or service of suit, for purposes of timely reporting to the applicants' Claims-Made insurers before expiration? Yes No
- Have all such claims or specific circumstances reasonably likely to give rise to a claim been made under all the applicants' current Claims-Made policies and accepted by all current insurers for coverage thereunder? Yes No
 If No, explain: _____

Note: Written notice, demand, service of suit, and specific circumstances reasonably likely to give rise to a written notice, demand or service of suit, known to any applicant or any insurer prior to the requested effective date for any applicant will be excluded.

SECTION F. PREVIOUS INSURANCE

N/A if The Prior Acts Warranty is Answered

- Professional Liability Insurance Coverage Information. Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence

- General Liability Insurance Coverage Information: Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence

		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence
--	--	------------	------------	----	--

3. Excess Liability Insurance Coverage Information. Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence
		\$ / \$	\$ / \$	\$	Claims-Made Retro Date: Occurrence

4. *Missouri Applicants Disregard This Question*

Has any Primary or Excess Liability insurer refused, canceled or non-renewed insurance for any applicant in the past? Yes No

If Yes, explain: _____

If Sexual Molestation Coverage is desired, please complete the following questions:

N/A

5. Have you or any employee, volunteer or other person working for you, ever been arrested or convicted of a crime? Yes, Explain: _____ No
6. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? Yes, Explain: _____ No
7. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? Yes, Explain: _____ No
8. Does your facility do background checks on all employees and volunteers? Yes No
 - a. Type: **Federal:** Yes No **State:** Yes No **County:** Yes No

Sexual Molestation and Abuse Sublimit requested:

\$25,000 \$100,000 \$250,000 \$500,000 \$1,000,000

a. Retroactive Date:

SECTION G. – FRAUD WARNING, DECLARATION & CERTIFICATION, AND SIGNATURE

NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND & WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete or misleading information is guilty of a felony of the third degree.

insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO TENNESSEE & VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT DECLARES TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY SUPPLEMENTS ATTACHED HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

Signature of Applicant Signature of Broker/Agent

Title Date

Date Signed by Licensed Resident Agent
(Where Required By Law)