

- Western World Insurance Company
- Tudor Insurance Company
- Stratford Insurance Company

Application For Adult Day Care Centers

1. Name of Applicant _____
 Street Address _____
 City _____ State _____ Zip _____
 Applicant's Web Site Address _____

2. Individual Corporation Partnership Professional Association Non-Profit Corp.
 Other (Explain) _____

3. Phone number for inspection: _____ Agent phone number: _____
 Contact person: _____

4. Date established: _____

5. LIMITS OF INSURANCE REQUESTED

| | | |
|--|----------|--------------------------------|
| General Aggregate Limit (Other than Products-Completed Operations) | \$ _____ | |
| Products-Completed Operations Aggregate Limit | \$ _____ | any one person or organization |
| Personal and Advertising Injury Limit | \$ _____ | |
| Each Occurrence Limit | \$ _____ | |
| Damage to Premises Rented to You (Up to \$50,000 limit available) | \$ _____ | any one premise |
| Medical Expense Limit (Up to \$5,000 limit available) | \$ _____ | any one person |
| Each Professional Incident Limit (if applicable) | \$ _____ | |

6. Effective Dates Desired: From _____ To _____

7. Prior insurance carrier and loss history. If new venture, check here.

| Insurance Company | Policy Period | Limits of Liability | Premium | Occurrence or Claims Made | Losses (attach details) |
|-------------------|---------------|---------------------|---------|---------------------------|-------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

8. Is applicant engaged in, owned by, associated with or involved in any other enterprises? Yes No
 If yes, provide details _____

9. Are you licensed by the state? Yes No
 License Number: _____ Expiration date of license: _____ License Capacity: _____

Has license ever been revoked or suspended? Yes No

10. What is maximum number of clients on premises at one time? _____ Average daily attendance? _____
 Please describe all the activities at this facility: _____

Any overnight stays? Yes No If yes, please attach details.

11. Transportation provided? Yes No Own-vehicles Contracted

If yes, provide full details. _____

12. Indicate type of facility: Social Medical/Mental

Describe: _____

13. How many non-ambulatory clients are there? _____

On what floor are the non-ambulatory clients? _____

How many Alzheimer's afflicted clients? _____

Staff-to-client ratio? _____

How many medical/mental clients? _____

How many over 65 but mentally and physically fully-functional? _____

Describe how injuries or illnesses are handled: _____

14. List medications administered and in what form given: _____

Given under prescription of MD? _____

Any medical treatment provided? _____

15. Any counseling therapy provided? _____

16. Is this an in-home facility? _____

If yes, please describe premises arrangements for clients: _____

17. Describe nature and frequency of off-premises field trips: _____

Provide staff-to-client ratio during excursions: _____

18. Describe the building, including age, construction, alarms and sprinklers: _____

of Floors _____ Stairs _____ Elevators? _____

Is the insured responsible for maintenance? Yes No

Is there a written emergency evacuation plan in place? Yes No

18A. Is there a swimming pool? _____ How often used? _____ How deep is the water? _____

What safety equipment is provided? _____

How supervised? _____

19. Patient breakdown by age group: 18 to 35 years _____ 51 to 65 years _____

36 to 50 years _____ Over 65 years _____

20. What precautions are taken to keep track of clients? _____

Sign out procedure? _____

Alarms on doors? _____ Other? Describe on back of form.

21. Indicate numbers of each type of employee:

(A) MD's _____ (E) Psychologists _____ (H) Podiatrist _____

(B) RN's _____ (F) Therapists _____ (I) Dentist _____

(C) LPN's _____ (G) Counselors _____ (J) Other (Describe) _____

(D) Nurses Aides _____

22. Who of the above employees are required to maintain their own Professional Liability insurance coverage?

Limits required? \$ _____ Certificates required? Yes No

23. How are employees screened? _____

24. What other services, such as beauty, podiatry or dental, are provided either by staff or by independent contractors?

Provide details. _____

25. Do you require certificates of insurance from all contracted professionals (not employees)? Yes No

What limits do you require? _____

26. Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? If yes, please provide full details. Yes No

27. Has applicant, or any other person for whom coverage is being requested, had any liability application denied, policy canceled or policy not renewed in the past three (3) years? If yes, please provide full details. Yes No

IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS #28 THROUGH 32.

If not desired, please sign application at bottom of page.

28. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? If yes, please provide details. Yes No

29. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? If yes, please provide details. Yes No

30. 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? If yes, please describe. Yes No

31. Does your facility do background checks on all employees and volunteers? Yes No

Describe types of checks done (prior employer, police, etc.) _____

32. Sexual Molestation sublimit wanted:
 \$25,000/50,000 \$50,000/100,000 \$100,000/300,000 \$300,000/300,000

Notice to applicants: In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.

Applicant's Signature: _____
(A quote will not be provided without an applicant's signature.)

Title: _____

Date: _____

Agent's Signature: _____

Date: _____

Upon requesting quotes and/or placement for the coverage listed herein, the producing retail broker hereby confirms that he/she has performed any and all diligent searches, as may be required by statute, for coverage through licensed carriers or other means of placement. Where allowed by governing statutes, "diligent effort" may not require an actual physical search and declination on each risk, but may be based on the retail producing broker's own experience, opinion and overall knowledge of acceptability in the admitted marketplace.