# ADULT DAY CARE GENERAL LIABILITY APPLICATION

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| Applicant’s Name:              Mailing Address:              Location Address:               | Agency Name:       Agent No.:       Address:              E-mail:       Phone No.:        |

**PROPOSED EFFECTIVE DATE: From**       **To**       **12:01 A.M., Standard Time at the address of the Applicant**

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE “NOT APPLICABLE” (N/A)

**Applicant is:** [ ]  Individual [ ]  Corporation [ ]  Partnership [ ]  Joint Venture

[ ]  Limited Liability Company [ ]  Other (Specify):

**Website Address:**

**E-mail Address:**       **Phone No.:**

**Limits Of Liability & Deductible Requested:**

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| General Aggregate (other than Products/Completed Operations) | $      |
| Products & Completed Operations Aggregate | $      |
| Personal & Advertising Injury (any one person or organization) | $      |
| Each Occurrence | $      |
| Damage To Premises Rented To You (any one premise) | $      |
| Medical Expense (any one person) | $      |
| Errors and Omissions Coverage Each Claim(Included up to General Liability Limits) Aggregate | $     $      |
| Sexual and/or Physical Abuse Coverage(Included up to $100,000/$300,000 limits—cannot exceed General Liability Limits) | [ ]  $100,000/$300,000[ ]  $300,000/$300,000[ ]  Other |
| Other Coverage, Restrictions, and/or Endorsements:      | $      |
| Deductible | $      |

**1. Number of years in business?**

**2. Is applicant licensed?** [ ]  Yes [ ]  No

Is a license required by the state? [ ]  Yes [ ]  No

**3. What is maximum number of clients permitted by license?**

**4. What is maximum number of clients on premises at any one time?**

Average daily attendance?

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| **5. Describe all activities at this facility:**       |

**6. Indicate type of facility:** [ ]  Social [ ]  Medical [ ]  Mental

**7. Indicate type of counseling, if any, provided:** [ ]  Financial [ ]  Medical

**8. Is this an in-home facility?** [ ]  Yes [ ]  No

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| If yes, explain:       |

**9. Does applicant provide assisted living facilities?** [ ]  Yes [ ]  No

**10. Is there a swimming pool on the premises?** [ ]  Yes [ ]  No

If yes:

**a.** Number of pools:

**b.** Pool area fenced with self-latching gate? [ ]  Yes [ ]  No

**c.** Depths marked? [ ]  Yes [ ]  No

**d.** Rules posted? [ ]  Yes [ ]  No

**e.** Life safety equipment at poolside? [ ]  Yes [ ]  No

 **f.** Is there a diving board, platform or slide? [ ]  Yes [ ]  No

**g.** Is a certified lifeguard or CPR certified attendant present at all times? [ ]  Yes [ ]  No

**h.** Are all swimming pools, wading pools, hot tubs and spas in compliance with the federal Virginia Graeme Baker Pool and Spa Safety Act? [ ]  Yes [ ]  No

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| **11. Describe any special equipment on premises:**       |

**12. Any off-premises field trips?** [ ]  Yes [ ]  No

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| If so, how many?       Describe:       |

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| **13. Describe the building, including age, construction, number of stories, alarms, sprinklers, etc.:**       |

**14. Are there any non-ambulatory attendees?** [ ]  Yes [ ]  No

If yes: How many?

**15. Are there any attendees with dementia, including Alzheimer’s?** [ ]  Yes [ ]  No

If yes: How many?

Are all exits equipped with anti-wandering devices? [ ]  Yes [ ]  No

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| **16. Describe how injuries or illnesses are handled:**       |

**17. Is there a doctor on staff or on call?** [ ]  Yes [ ]  No

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| If yes, explain:       |

**18. Does applicant have Workers’ Compensation coverage in force?** [ ]  Yes [ ]  No

**19. Ratio of caregivers to clients:**

**20. Total number of employees:**

**21. Does applicant subcontract any operations?** [ ]  Yes [ ]  No

If yes:

**a**.Description of operations subcontracted:

**b.** Annual cost of subcontracted work:

**c**.Are all subcontractors required to carry General Liability Insurance? [ ]  Yes [ ]  No

If yes, minimum limits required:

If no, what percentage of total subcontracted costs are uninsured?

**d.** Are all subcontractors required to carry Workers Compensation Insurance? [ ]  Yes [ ]  No

**e**.Are certificates of insurance required from all subcontractors? [ ]  Yes [ ]  No

**f.** Is applicant included as an additional insured on all subcontractors’ policies? [ ]  Yes [ ]  No

**22. Is there any overnight exposure?** [ ]  Yes [ ]  No

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| If yes, explain:       |

**23. Is there any physical therapy exposure at this facility?** [ ]  Yes [ ]  No

**24. Is there any administering of medicine at this facility?** [ ]  Yes [ ]  No

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| If yes, explain:       |

**25. Has the applicant had any previous or pending allegations of sexual and/or physical abuse?** [ ]  Yes [ ]  No

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| If yes, explain:       |

**26. During the past three years, has any company ever cancelled, declined or refused to issue similar insurance to the applicant?** (Not applicable in Missouri) [ ]  Yes [ ]  No

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| If yes, explain:       |

**27. Does applicant have an accident and health policy?** [ ]  Yes [ ]  No

If yes, what limits?

**28. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies?** [ ]  Yes [ ]  No

If yes, describe:

**29. Does applicant have other business ventures for which coverage is not requested?** [ ]  Yes [ ]  No

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| If yes, explain and advise where insured:       |

**30. Additional Insured Information:**

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| **Name** | **Address** | **Interest** |
|       |       |       |
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**31. Prior Carrier Information:**

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|  | **Year:**      | **Year:**      | **Year:**      |
| **Carrier** |       |       |       |
| **Policy No.** |       |       |       |
| **Coverage** |       |       |       |
| **Occurrence or Claims Made** |       |       |       |
| **Total Premium** |       |       |       |

**32. Loss History:**

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| **Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior three years.** [ ]  Check if no losses last three years. |
| **Date ofLoss** | **Description of Loss** | **AmountPaid** | **AmountReserved** | **Claim Status(Open or Closed)** |
|       |       |       |       |       |
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This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**FRAUD WARNING:** 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. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT or WA.)

**FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON):** Any person who intentionally presents a materially false statement in an application for insurance may be guilty of a criminal offense and subject to penalties
under state law.

**FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON):** 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.

**APPLICANT’S STATEMENT:**

I have read the above application and I declare that to the best of my knowledge and belief all of the foregoing state-ments are true, and that these statements are offered as an inducement to us to issue the policy for which I am applying. (Kansas: This does not constitute a warranty.)

APPLICANT’S SIGNATURE: DATE:

CO-APPLICANT’S SIGNATURE: DATE:

PRODUCER’S SIGNATURE: DATE:

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|  | **IMPORTANT NOTICE** |  |
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| As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided. |