**HALFWAY HOUSE 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 and Deductible Requested:**

|  |  |
| --- | --- |
| General Aggregate (other than Products/Completed Operations) | $      |
| Products and Completed Operations Aggregate | $      |
| Personal and 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(Limits must be equal to General Liability limits) Aggregate | $     $      |
| Sexual and/or Physical Abuse Coverage | [ ]  $ 25,000/$ 50,000 (included) |
| [ ]  $ 50,000/$100,000 |
| [ ]  $100,000/$300,000 |
| Other Coverages, Restrictions and/or Endorsements:       | $      |
| Deductible | $      |

**1. Applicant operates as:** [ ]  Profit [ ]  Nonprofit Number of years in operation:

**2. How long under present management?**       (If fewer than five years, attach principals’ resumes. If principals in the firm do not have a health care background, then also include the resume of the individual responsible for hiring, screening and monitoring the work activities of employees.)

**3. Is facility owned by physician(s)?** [ ]  Yes [ ]  No

If yes, is physician(s) involved in day-to-day operations? [ ]  Yes [ ]  No

**4. Type of operation:**

[ ]  Birth control, pregnancy or abortion counseling/clinic [ ]  Mission or settlement house

[ ]  Blood testing or communicable disease clinic [ ]  Non-medical drug and alcohol rehabilitation center

[ ]  Crises center (rape, domestic violence, etc.) [ ]  Outpatient aftercare and support program (AA,

[ ]  Food bank Al-Anon, etc.)

[ ]  Halfway house [ ]  Outpatient counseling or guidance center

[ ]  Healthcare clinic [ ]  Prisoners work release or rehabilitation program

[ ]  Homeless shelter [ ]  Psychiatric institution

[ ]  Hospice facility [ ]  Soup kitchen

[ ]  Medical urgent care facility [ ]  Youth hostel

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| Describe type of operation and services provided (attach brochure and/or advertising material if available):       |

**5. Does applicant provide any off-premises services?** [ ]  Yes [ ]  No

If yes, advise:

**6. Any previous or pending allegations of sexual and/or physical abuse?** [ ]  Yes [ ]  No

**7. Total number of employees:**

**8. As part of hiring/screening of new employees, does applicant:**

**a.** Obtain copies of their professional licenses/certifications? [ ]  Yes [ ]  No

**b.** Contact applicants’ references before they are hired? [ ]  Yes [ ]  No

**c.** Require that they carry their own professional liability policy? [ ]  Yes [ ]  No

**9. Operations conducted in the following states:**

State:       Licensed with state? [ ]  Yes [ ]  No License No.:

State:       Licensed with state? [ ]  Yes [ ]  No License No.:

State:       Licensed with state? [ ]  Yes [ ]  No License No.:

**10. Has license ever been revoked?** [ ]  Yes [ ]  No

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| If yes, explain:       |

**11. Name all subsidiary companies/locations and others coming under applicant’s control:** (if none, please state)

**12. Has applicant sold, acquired or discontinued any operations in the last five years?** [ ]  Yes [ ]  No

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| If yes, explain:       |

**13. Is at least one of the principals or an Administrator/Director involved in the operation on a full-time basis?** [ ]  Yes [ ]  No

**14. Physical features of risk:**

**a.** Year built:

**b.** Construction of building:

**c.** Number of floors:       On which floor(s) is applicant located?

Square foot area occupied by applicant:

**d.** Equipped with sprinkler system? [ ]  Yes [ ]  No

Equipped with fire alarm? [ ]  Yes [ ]  No

If yes: [ ]  Central station [ ]  Local alarm

Equipped with smoke detectors? [ ]  Yes [ ]  No

If yes, how many on each floor?

**e.** Number of fire extinguishers on premises:       Number of fire escapes:

**f.** Is smoking allowed on premises? [ ]  Yes [ ]  No

If yes, where is it permitted?

**g.** Is there a swimming pool or hot tub/spa on premises? [ ]  Yes [ ]  No

If yes:

• Number of pools:

• Are the pools fully fenced with self-latching gates? [ ]  Yes [ ]  No

• Are the rules posted? [ ]  Yes [ ]  No

• Is there life-safety equipment at poolside? [ ]  Yes [ ]  No

• Is there a diving board, platform or slide? [ ]  Yes [ ]  No

If yes, height of each:

• 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

**h.** Was building originally built for this type of occupancy? [ ]  Yes [ ]  No

**15. Evacuation procedures:**

**a.** Does applicant have a written Emergency Evacuation Plan? [ ]  Yes [ ]  No

**b.** Does evacuation plan include advance agreement for transportation and temporary shelter? [ ]  Yes [ ]  No

**c.** Are evacuation procedures posted in all parts of the facility? [ ]  Yes [ ]  No

If yes, are posted evacuation procedures bilingual? [ ]  Yes [ ]  No

**d.** How often are drills conducted?

**16. State patients’/residents’ ages:** Youngest:       Oldest:       Average age:

**17. Physicians on premises, if any, are:**

[ ]  Private practitioners (personal physicians of the residents)

[ ]  Employees of applicant

[ ]  Contracted physicians through written contract with applicant

If contracted physician, are certificates/evidence of professional liability insurance required and kept on file? [ ]  Yes [ ]  No

**18. Do services provided include?**

Infusion therapy? [ ]  Yes [ ]  No

Dialysis? [ ]  Yes [ ]  No

Physical therapy? [ ]  Yes [ ]  No

Does treatment process involve the administration of methadone or other drugs? [ ]  Yes [ ]  No

**19. Are employees authorized to use their personal vehicles to transport residents or patients?** [ ]  Yes [ ]  No

**20. Are residents/patients placed in applicant’s facility by court order?** [ ]  Yes [ ]  No

**21. Any involvement in medical detoxification?** [ ]  Yes [ ]  No

**22. Does facility accept prisoners?** [ ]  Yes [ ]  No

**23. Does facility accept teens with a past history of violence or attempted suicide?** [ ]  Yes [ ]  No

**24. Does facility provide pregnancy and/or abortion counseling services?** [ ]  Yes [ ]  No

**25. Does facility, if an inpatient facility, accept children under the age of eighteen (18)?** [ ]  Yes [ ]  No

If yes, does applicant also require the child’s guardian to be in residence at the same facility? [ ]  Yes [ ]  No

**26. Is facility a foster home or foster care facility?** [ ]  Yes [ ]  No

**27. Does facility provide inpatient services or permanent housing for either of the following:**

**a. Developmentally Disabled**—Adults or children able to care for themselves despite their disability or mental retardation. Examples of this category include Down Syndrome, autism and brain injuries. This category does not include individuals whose primary diagnosis is an emotional or mental
illness. [ ]  Yes [ ]  No

**b. Mentally Disabled**—Adults or children able to care for themselves (with substantial numbers able to hold jobs). Behavior is controlled through medication and monitored by their personal physician. This category would include individuals whose primary diagnosis is an emotional or mental illness including, but not limited to, schizophrenia, psychopathic and sociopathic diagnosis. [ ]  Yes [ ]  No

**28. Does applicant provide bed and board facilities?** [ ]  Yes [ ]  No

If yes, number of beds:

Length of stay: From (shortest):       To (longest):       Average:

**29. Does applicant provide outpatient services?** [ ]  Yes [ ]  No

If yes, number of annual outpatient visits:

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| **30. Explain arrangement for medical emergencies** (i.e., M.D. on call, transfer arrangements with hospital, etc.):       |

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

**32. Does applicant have any contractual agreements wherein applicant assumes the liability of
others?** [ ]  Yes [ ]  No

If yes, attach a list of each entity that has requested to be named as an additional insured and the type of service(s) applicant provides.

**33. Any other premises or operations exposures not stated in this application?** [ ]  Yes [ ]  No

If yes, attach a complete description and underwriting/rating information.

**34. During the past five years, have any claims been made or suits brought against the applicant because of alleged malpractice, error, mistake or premises accident arising in any manner out of applicant’s operation?** [ ]  Yes [ ]  No

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| If yes, advise date and details:       |

**35. Additional Insured Information:**

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| --- | --- | --- |
| **Name** | **Address** | **Interest** |
|       |       |       |
|       |       |       |
|       |       |       |

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

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| If yes, explain:       |

**37. 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

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| If yes, describe:       |

**38. 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:       |

**39. Schedule of Hazards:**

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| --- | --- | --- | --- | --- |
| **Loc.No.** | **Classification Description** | **Class.Code** | **Exposure** | **Premium Basis**(s) Gross Sales(p) Payroll(a) Area (c) Total Cost(t) Other |
|      |       |       |       |       |
|      |       |       |       |       |
|      |       |       |       |       |
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**40. Prior Carrier Information:**

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| --- | --- | --- | --- | --- | --- |
|  | **Year:**      | **Year:**      | **Year:**      | **Year:**      | **Year:**      |
| **Carrier** |       |       |       |       |       |
| **Policy Number** |       |       |       |       |       |
| **Coverage** |       |       |       |       |       |
| **Occurrence or Claims Made** |       |       |       |       |       |
| **Total Premium** | $      | $      | $      | $      | $      |

**41. 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 five years.** [ ]  Check if no losses last five years. |
| **Date of Loss** | **Description of Loss** | **Amount Paid** | **Amount Reserved** | **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 statements 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. |