**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:**

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| 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** |
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**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)** |
|  |  | $ | $ |  |
|  |  | $ | $ |  |
|  |  | $ | $ |  |
|  |  | $ | $ |  |
|  |  | $ | $ |  |

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. | | |