



Mid Valley General Agency LLC
 888 Madison St NE, Ste 100, Salem, OR 97301
 Phone: 888-565-7001 ♦ Fax: 888-265-7353
quotes@midvalleyga.com

HALFWAY HOUSE GENERAL LIABILITY APPLICATION

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 (Limits must be equal to General Liability limits)	Each Claim Aggregate	\$ \$
Sexual and/or Physical Abuse Coverage		<input type="checkbox"/> \$ 25,000/\$ 50,000 (included) <input type="checkbox"/> \$ 50,000/\$100,000 <input type="checkbox"/> \$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:

- | | |
|---|---|
| <input type="checkbox"/> Birth control, pregnancy or abortion counseling/clinic | <input type="checkbox"/> Mission or settlement house |
| <input type="checkbox"/> Blood testing or communicable disease clinic | <input type="checkbox"/> Non-medical drug and alcohol rehabilitation center |
| <input type="checkbox"/> Crises center (rape, domestic violence, etc.) | <input type="checkbox"/> Outpatient aftercare and support program (AA, Al-Anon, etc.) |
| <input type="checkbox"/> Food bank | <input type="checkbox"/> Outpatient counseling or guidance center |
| <input type="checkbox"/> Halfway house | <input type="checkbox"/> Prisoners work release or rehabilitation program |
| <input type="checkbox"/> Healthcare clinic | <input type="checkbox"/> Psychiatric institution |
| <input type="checkbox"/> Homeless shelter | <input type="checkbox"/> Soup kitchen |
| <input type="checkbox"/> Hospice facility | <input type="checkbox"/> Youth hostel |
| <input type="checkbox"/> Medical urgent care facility | |

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
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
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:..... _____
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
If yes, advise date and details: _____

35. Additional Insured Information:

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
 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
 If yes, describe: _____

38. Does applicant have other business ventures for which coverage is not requested? Yes No
 If yes, explain and advise where insured: _____

39. Schedule of Hazards:

Loc. No.	Classification Description	Class. Code	Exposure	Premium Basis (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other

40. Prior Carrier Information:

	Year:	Year:	Year:	Year:	Year:
Carrier					
Policy Number					
Coverage					
Occurrence or Claims Made					
Total Premium	\$	\$	\$	\$	\$

41. Loss History:

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: _____

IMPORTANT NOTICE

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.