



## Adult Day Care General Liability Application

Applicant's Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 \_\_\_\_\_  
 Location \_\_\_\_\_  
 \_\_\_\_\_  
 Web Site Address \_\_\_\_\_

Agency Name \_\_\_\_\_  
 Agent \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 E-Mail \_\_\_\_\_  
 Phone \_\_\_\_\_

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

**Applicant is:**  Individual  Corporation  Partnership  Joint Venture  
 Limited Liability Company  Other (Specify): \_\_\_\_\_

LIMITS OF LIABILITY REQUESTED		PREMIUMS
General Aggregate	\$	Premises/Operations
Products & Completed Operations Aggregate	\$	
Personal & Advertising Injury	\$	Products/Completed Operations
Each Occurrence	\$	
Fire Damage (any one fire)	\$	Other
Medical Expense (any one person)	\$	
Other Coverages, Restrictions, and/or Endorsements		Total
Deductible	\$	

- A. Number of years in business?** \_\_\_\_\_
- B. Is applicant licensed?** .....  Yes  No  
 Is a license required by the state? .....  Yes  No
- C. What is maximum number of clients permitted by license?** \_\_\_\_\_
- D. What is maximum number of clients on premises at any one time?** \_\_\_\_\_  
 Average daily attendance? \_\_\_\_\_
- E. Please describe all the activities at this facility:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- F. Indicate type of facility:**  Social  Medical  Mental
- G. Indicate type of counseling, if any, provided:**  Financial  Medical

- H. Is this an in-home facility?**.....  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
- I. Is there a swimming pool on the premises?**.....  Yes  No  
 If yes:  
 1. Number of pools? \_\_\_\_\_  
 2. Are the pools fenced? .....  Yes  No  
 3. Are the rules posted? .....  Yes  No  
 4. Is there life-safety equipment at poolside? .....  Yes  No  
 5. Is there a diving board, platform, or slide? .....  Yes  No  
 6. Is a certified lifeguard or CPR certified attendant present at all times? .....  Yes  No
- J. Describe any special equipment on premises:** \_\_\_\_\_  
 \_\_\_\_\_
- K. Any off-premises field trips?** .....  Yes  No  
 If so, how many? \_\_\_\_\_ Describe: \_\_\_\_\_  
 \_\_\_\_\_
- L. Describe the building, including age, construction, number of stories, alarms, sprinklers, etc.:** \_\_\_\_\_  
 \_\_\_\_\_
- M. Are there any non-ambulatory attendees?**.....  Yes  No  
 If yes, how many? \_\_\_\_\_
- N. Are there any Alzheimer's afflicted adults?** .....  Yes  No  
 If yes: How many? \_\_\_\_\_  
 Are there anti-wandering devices on all the exits? .....  Yes  No
- O. Describe how injuries or illnesses are handled:** \_\_\_\_\_  
 \_\_\_\_\_
- P. Is there a doctor on staff or on call?**.....  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
- Q. Does applicant have Workers' Compensation coverage in force?** .....  Yes  No
- R. Ratio of caregivers to clients:** \_\_\_\_\_
- S. Total number of employees:** \_\_\_\_\_
- T. Is there any overnight exposure?** .....  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
- U. Is there any physical therapy exposure at this facility?** .....  Yes  No
- V. Is there any administering of medicine at this facility?** .....  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
- W. Has the applicant had any past or present allegations of physical/sexual abuse?**.....  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

X. 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

If yes, please explain: \_\_\_\_\_

Y. Does applicant have an accident and health policy? .....  Yes  No

If yes, what limits? \_\_\_\_\_

Z. Does applicant have other business ventures for which coverage is not requested? .....  Yes  No

If yes, please explain and advise where insured: \_\_\_\_\_

**Previous Insurer and 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 three years.**  Loss run attached

YEAR	COMPANY	POL. NO.	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

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.

**APPLICABLE IN THE STATE OF NEW YORK:**

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**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.

NAME AND TITLE: \_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

AGENT NAME: \_\_\_\_\_ AGENT LICENSE NUMBER: \_\_\_\_\_

*(Applicable to Florida Agents Only.)*

IOWA LICENSED AGENT: \_\_\_\_\_

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT: \_\_\_\_\_

**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.

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"