

- Western World Insurance Company
- Tudor Insurance Company
- Stratford Insurance Company

Application  
For  
**Adult Day Care Centers**

1. Name of Applicant \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Applicant's Web Site Address \_\_\_\_\_

2.  Individual  Corporation  Partnership  Professional Association  Non-Profit Corp.  
 Other (Explain) \_\_\_\_\_

3. Phone number for inspection: \_\_\_\_\_ Agent phone number: \_\_\_\_\_  
 Contact person: \_\_\_\_\_

4. Date established: \_\_\_\_\_

5. LIMITS OF INSURANCE REQUESTED  
 General Aggregate Limit (Other than Products – Completed Operations) \$ \_\_\_\_\_  
 Products-Completed Operations Aggregate Limit \$ \_\_\_\_\_  
 Personal and Advertising Injury Limit \$ \_\_\_\_\_  
 Each Occurrence Limit \$ \_\_\_\_\_  
 Fire Damage Limit (up to \$50,000 limit available) \$ \_\_\_\_\_ any one (1) fire  
 Medical Expense Limit (up to \$5,000 limit available) \$ \_\_\_\_\_ any one (1) person  
 Each Professional Incident Limit (if applicable) \$ \_\_\_\_\_

6. Effective Dates Desired: From \_\_\_\_\_ To \_\_\_\_\_

7. Prior insurance carrier and loss history. If new venture, check here.

Insurance Company	Policy Period	Limits of Liability	Premium	Occurrence or Claims Made	Losses (attach details)

8. Is applicant engaged in, owned by, associated with or involved in any other enterprises?  Yes  No  
 If yes, provide details \_\_\_\_\_

9. Are you licensed by the state?  Yes  No  
 License Number: \_\_\_\_\_ Expiration date of license: \_\_\_\_\_ License Capacity: \_\_\_\_\_  
 Has license ever been revoked or suspended?  Yes  No

10. What is maximum number of clients on premises at one time? \_\_\_\_\_ Average daily attendance? \_\_\_\_\_  
 Please describe all the activities at this facility: \_\_\_\_\_

Any overnight stays?  Yes  No If yes, please attach details.

11. Transportation provided?  Yes  No  Own-Vehicles  Contracted

If yes, provide full details. \_\_\_\_\_

12. Indicate type of facility:  Social  Medical/Mental  
Describe: \_\_\_\_\_

13. How many non-ambulatory clients are there? \_\_\_\_\_  
On what floor are the non-ambulatory clients? \_\_\_\_\_  
How many Alzheimer's afflicted clients? \_\_\_\_\_  
Staff-to-client ratio? \_\_\_\_\_  
How many medical/mental clients? \_\_\_\_\_  
How many over 65 but mentally and physically fully-functional? \_\_\_\_\_  
Describe how injuries or illness are handled: \_\_\_\_\_  
\_\_\_\_\_

14. List medications administered and in what form given: \_\_\_\_\_  
Given under prescription of MD? \_\_\_\_\_  
Any medical treatment provided? \_\_\_\_\_

15. Any counseling therapy provided? \_\_\_\_\_

16. Is this an in-home facility? \_\_\_\_\_  
If yes, please describe premises arrangements for clients: \_\_\_\_\_

17. Describe nature and frequency of off-premises field trips: \_\_\_\_\_  
\_\_\_\_\_

Provide staff-to-client ratio during excursions: \_\_\_\_\_

18. Describe the building, including age, construction, alarms and sprinklers: \_\_\_\_\_

# of Floors \_\_\_\_\_ Stairs \_\_\_\_\_ Elevators? \_\_\_\_\_

Is the insured responsible for maintenance?  Yes  No

Is there a written emergency evacuation plan in place?  Yes  No

18A. Is there a swimming pool? \_\_\_\_\_ How often used? \_\_\_\_\_ How deep is the water? \_\_\_\_\_  
What safety equipment is provided? \_\_\_\_\_  
How supervised? \_\_\_\_\_

19. Patient breakdown by age group: 18 to 35 years \_\_\_\_\_ 51 to 65 years \_\_\_\_\_  
36 to 50 years \_\_\_\_\_ Over 65 years \_\_\_\_\_

20. What precautions are taken to keep track of clients? \_\_\_\_\_  
Sign out procedure? \_\_\_\_\_  
Alarms on doors? \_\_\_\_\_ Other? Describe on back of form.

21. Indicate numbers of each type of employee:  
(A) MD's \_\_\_\_\_ (E) Psychologists \_\_\_\_\_ (H) Podiatrist \_\_\_\_\_  
(B) RN's \_\_\_\_\_ (F) Therapists \_\_\_\_\_ (I) Dentist \_\_\_\_\_  
(C) LPN's \_\_\_\_\_ (G) Counselors \_\_\_\_\_ (J) Other (Describe) \_\_\_\_\_  
(D) Nurses Aides \_\_\_\_\_

22. Who of the above employees are required to maintain their own Professional Liability insurance coverage?  
Limits required? \$ \_\_\_\_\_ Certificates required?  Yes  No

23. How are employees screened? \_\_\_\_\_

24. What other services, such as beauty, podiatry or dental, are provided either by staff or by independent contractors? Provide details. \_\_\_\_\_
25. Do you require certificates of insurance from all contracted professionals (not employees)?  Yes  No  
What limits do you require? \_\_\_\_\_
26. Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? If yes, please provide full details.  Yes  No  
\_\_\_\_\_
27. Has applicant, or any other person for whom coverage is being requested, had any liability application denied, policy canceled or policy not renewed in the past three (3) years? If yes, please provide full details.  Yes  No  
\_\_\_\_\_

**IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS 28 THROUGH 32.**  
If not desired, please sign application at bottom of page.

28. Have you or any employee, volunteer or other person working for you, ever been arrested or convicted of a crime? If yes, please provide details.  Yes  No  
\_\_\_\_\_
29. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? If yes, please provide details.  Yes  No  
\_\_\_\_\_
30. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? If yes, please describe.  Yes  No  
\_\_\_\_\_
31. Does your facility do background checks on all employees and volunteers? Describe types of checks done (prior employer, police, etc.)  Yes  No  
\_\_\_\_\_
32. Sexual Molestation sublimit wanted:  
 \$25,000/50,000     \$50,000/100,000     \$100,000/300,000     \$300,000/300,000

Notice to applicants: In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.

Applicant's Signature: \_\_\_\_\_  
(A quote will not be provided without an applicant's signature.)

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Agent: \_\_\_\_\_