Member Companies of Western World Insurance Group

☐ Western World Insurance Company
☐ Tudor Insurance Company
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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Has license ever been revoked or suspended?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? ☐ Yes ☐ No
Describe types of checks done (prior employer, police, etc.) _____
_____

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: _____