Adult Day Care General Liability Application

Applicant's Name _____

Mailing Address _____

_____

Location _____

_____

Agent Name _____

Address _____

_____

PROPOSED EFFECTIVE DATE:

From _____ **To**_____

12:01 A.M., Standard Time at the address of the Applicant.

Applicant is: θ Individual θ Corporation θ Partnership θ Joint Venture

θ Limited Liability Company θ 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. Is applicant licensed? θ Yes θ No

B. What is maximum number of clients permitted by license? _____

C. What is maximum number of clients on premises at any one time?_____ Average daily attendance?_____

D. Please describe all the activities at this facility: _____

_____

_____

_____

E. Indicate type of facility: θ Social θ Medical θ Mental

F. Indicate type of counseling, if any, provided: θ Financial θ Medical

G. In this an in-home facility? θ Yes θ No If yes, please explain: _____

_____

H. Is there a swimming pool on the premises? θ Yes θ No If yes, is it fenced? θ Yes θ No

I. Describe any special equipment on premises: _____

_____

J. Any off-premises field trips? θ Yes θ No If so, how many?_____ Describe: _____

_____

K. Describe the building, including age, construction, number of stories, alarms, sprinklers, etc.: _____

_____

_____

L. Are there any non-ambulatory attendees? θ Yes θ No If yes, how many? _____

M. Are there any Alzheimer's afflicted adults? θ Yes θ No If yes, how many? _____

N. Describe how injuries or illnesses are handled: _____

_____

O. Is there a doctor on staff or on call? θ Yes θ No If yes, please explain: _____

_____

P. Does applicant have Workers' Compensation coverage in force? θ Yes θ No

Q. Does applicant lease employees? θ Yes θ No

R. Total number of employees: _____

S. Is there any overnight exposure? θ Yes θ No If yes, please explain: _____

T. Is there any physical therapy exposure at this facility? θ Yes θ No

U. Is there any administering of medicine at this facility? θ Yes θ No If yes, please explain: _____

_____

V. During the past three years has any company ever cancelled, declined or refused to issue similar insurance to the applicant? (Not applicable in Missouri.)

θ Yes θ No If yes, explain: _____

W. Does applicant have accident and health policy? θ Yes θ No If yes, what limits? _____

Previous Insurer: Indicate premium and losses for the past three years. Describe all losses.

YEAR	COMPANY	POL. #	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

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.

APPLICANT'S SIGNATURE _____ Date _____

AGENT NAME _____

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

Agent Name: _____

Agency Name: _____

Email Address: _____

Phone Number: _____

Please select your option below:

Save Application

Print Application

Agent Name: _____

Agency Name: _____

Email Address: _____

Phone Number: _____

Please select your option below:

Save Application

Print Application