

3. Type of operation:

- Crises centers (rape, domestic violence, etc.)
- Halfway houses
- Homeless shelters
- Mission or settlement house
- Non-medical drug and alcohol rehabilitation center
- Outpatient aftercare and support program (AA, Al-Anon, etc.)
- Outpatient counseling or guidance center
- Birth control, pregnancy or abortion clinic
- Blood testing or communicable disease clinics
- Healthcare clinic
- Hospice facility
- Prisoners work-release or rehabilitation program
- Psychiatric institution
- Youth hostel

Describe type of operation and services provided (attach brochure and/or advertising material if available):

4. 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.: _____

5. Has license ever been revoked? Yes No

If yes, please explain: _____

6. Name all subsidiary companies/locations and others coming under applicant's control (if none, please state):

7. Has the applicant sold, acquired or discontinued any operations in the last five years?..... Yes No

If yes, please explain: _____

8. Is at least one of the principals or an Administrator/Director involved in the operation on a full-time basis? Yes No

9. Physical features of risk:

- a. Construction of building: _____
- b. Number of floors: _____ On which floor(s) is applicant located? _____
Square foot area occupied by the applicant: _____
- c. Year built: _____
- d. Equipped with sprinkler system? Yes No
Equipped with fire alarm? Yes No
 Central station Local alarm
Equipped with smoke detectors? Yes No
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
- h. Was building originally built for this type of occupancy? Yes No

10. Emergency procedures:

- a. Do you have a written Emergency Evacuation Plan?..... Yes No

- b. Does your plan include advance agreement of transportation and temporary shelter?..... Yes No
- c. Are evacuation procedures posted in all parts of your facility? Yes No
Bilingual?..... Yes No
- d. How often are drills conducted? _____

11. State patients'/residents' ages—from _____ (youngest) to _____ (oldest) Average age: _____

12. Physicians on premises, if any, are:

- Private practitioners (personal physicians of the resident)
- Employees of the 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

13. 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

14. Are employees authorized to use their personal vehicles to transport residents or patients?..... Yes No

15. Are residents/patients placed in applicant's facility by court order?..... Yes No

16. Any involvement in medical detoxification?..... Yes No

17. Does facility accept prisoners? Yes No

18. Does facility accept teens with a past history of violence or attempted suicide? Yes No

19. Does facility provide pregnancy and/or abortion counseling services?..... Yes No

20. 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

21. Is facility a foster home or foster care facility? Yes No

22. 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 Downs 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

23. Does the applicant provide bed and board facilities? Yes No

If yes, number of beds: _____

Length of stay: from _____ (shortest) to _____ (longest) Average: _____

24. Does the applicant provide outpatient services? Yes No

If yes, number of annual outpatient visits: _____

25. Explain arrangement for medical emergencies (i.e., M.D. on call, transfer arrangements with hospital, etc.):

26. 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

27. Total number of employees: _____

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

29. Does applicant have any contractual agreements wherein applicant assumes the liability of others? Yes No

If yes, please attach a list of each entity that has requested to be named as an additional insured and the type of service(s) applicant provides.

30. Any other premises or operations exposures not stated in this application? Yes No

If yes, attach a complete description and underwriting/rating information.

SCHEDULE OF HAZARDS									
Loc. No.	Classification	Class. Code	Premium Bases:		Terr.	Rate		Premium	
			(s) Gross Sales (a) Area (t) Other	(p) Payroll (c) Total Cost		Prem./ Ops.	Products/ Comp. Ops.	Prem./ Ops.	Products/ Comp. Ops.

31. 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, date: _____

If yes, please explain: _____

32. 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, please explain: _____

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. See loss run attached

Year	Company	Policy No.	Occurrence or Claims Made	Premium	Losses Paid	Losses Reserved	Description

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

If yes, explain and advise where insured: _____

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.

FRAUD WARNING (APPLICABLE IN FLORIDA):

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD WARNING (APPLICABLE IN MAINE):

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

FRAUD WARNING (APPLICABLE IN TENNESSEE 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.

FRAUD WARNING 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.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by an active owner, partner or executive officer)

PRODUCER'S SIGNATURE: _____ DATE: _____

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.