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   Has license ever been revoked or suspended?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: ______________________________