Commonwealth Underwriters Ltd.
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APPLICATION FOR ADULT DAYCARE CENTERS PROFESSIONAL AND GENERAL LIABILITY INSURANCE

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

ADDITIONAL DOCUMENTS TO BE SUBMITTED WITH EVERY APPLICATION

1. Is sample employment application attached?
2. Is sample advertising brochure attached?
3. Are current audited financial statements attached?

1. APPLICANT INFORMATION

a. Full name of applicant: _____
Please attach a list of entities to be considered as additional insureds including brief explanations of their interests, operations and relationship to applicant.

b. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)
Please attach list of additional locations.

c. Phone Number: ( ) _____

d. Requested Limits of Liability: $_____ Per Claim $_____ Annual Aggregate Deductible: _____

e. [ ] Individual [ ] Corporation [ ] For Profit [ ] Partnership [ ] Governmental [ ] Not for Profit [ ] Other _____

2. APPLICANT OPERATIONS

a. Number of years this facility has been:

(i) Operating: _____ (ii) Owned by current owners: _____ (iii) Managed by current management: _____

b. Are you:

(i) Licensed and certified as required by state and/or federal law? ..... **YES NO**
(ii) Licensed and approved by State Board of Health? ..... **YES NO**
(iii) Licensed by State Department on Aging? ..... **YES NO**
(iv) A member of a state or national association? ..... **YES NO**

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

d. Has the Applicant entered into any written indemnification agreements:

(i) Holding the applicant harmless? ..... **YES NO**
(ii) Holding any other party harmless? ..... **YES NO**
If Yes, to (i) or (ii) attach copies of agreements.

e. Gross Revenues:

	Past 12 Months	Next 12 Months
Medicaid	$_____	$_____
Medicare	$_____	$_____
Private Pay	$_____	$_____
Charitable	$_____	$_____
Total	$_____	$_____

3. APPLICANT MANAGEMENT

a. Please complete the following:

	Director of Nursing	Medical Director	Administrator
Employed	_____	_____	_____
Contracted	_____	_____	_____
Full-Time	_____	_____	_____
Part-Time	_____	_____	_____
Years at this Facility	_____	_____	_____
Years Experience	_____	_____	_____

b. Please provide name and qualifications of Medical Director: _____

_____

c. Does the applicant want to include coverage for the Medical Director? ..... **YES NO**

d. Do you report known or suspected incidents of abuse to local health or law enforcement agency? ..... **YES NO**

e. Do you have regularly scheduled staff meetings? ..... **YES NO**
If Yes, please indicate frequency: _____

f. Are written procedures in effect for incident reporting? ..... **YES NO**

g. Please provide name and title of the individual responsible for reviewing incident report and determining whether corrective action is necessary: _____

_____

h. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... **YES NO**
If Yes,
(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... **YES NO**
(ii) Provide the name and title of the Applicant's Privacy Officer. _____
Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

4. APPLICANT PROCEDURES

a. Please attach a description of the procedure for storing and dispensing medication.

b. Please attach the following:
(i) description of precautions taken to prevent clients from leaving premises without proper authorization.
(ii) description of precautions taken to prevent clients from being released to unauthorized persons.
(iii) description of precautions taken to prevent clients from accessing cooking areas, stoves, kilns.

c. Who determines if a client can no longer be served at the facility? _____

d. Are written attending physician orders required for:
(i) Dispensing of all drugs or medicines? ..... **YES NO**
(ii) Special dietary requirements? ..... **YES NO**
(iii) Any other specific therapy /treatment? ..... **YES NO**
(iv) Use of restraints? ..... **YES NO**

e. How long are client records maintained? _____

f. Is a client assessment conducted for new clients? ..... **YES NO**
If Yes, does this assessment include evaluation of:
(i) Mobility limitations? ..... **YES NO**
(ii) History of prior illnesses and injuries? ..... **YES NO**
(iii) Required assistance? ..... **YES NO**
(iv) Disorientation/combativeness? ..... **YES NO**

(v) Current medications? ..... **YES NO**

(vi) Continence? ..... **YES NO**

5. APPLICANT SERVICES/ACTIVITIES

a. Is the Center involved in any of the following:

(i) Fund raising activities? ..... **YES NO**

(ii) Craft fairs? ..... **YES NO**

(iii) Internships/Externships of health care students? ..... **YES NO**

If Yes, please attach description.

b. Does the Center provide the following services:

(i) Psychiatric assessments? ..... **YES NO**

(ii) Mental health counseling? ..... **YES NO**

(iii) Medical counseling? ..... **YES NO**

(iv) Financial counseling? ..... **YES NO**

(v) Alzheimer or dementia care? ..... **YES NO**

(vi) Physical or occupational therapy? ..... **YES NO**

(vii) Child or adolescent day care? ..... **YES NO**

(viii) Meals? ..... **YES NO**

If Yes, please attach description.

c. Are any offsite recreational or field trip activities undertaken? ..... **YES NO**

6. CLIENT PROFILE

a. What is the average number of clients per day?

b. Source of Payment: # of Clients

Medicaid _____

Medicare _____

Private Pay _____

c.

Age Group:	# of Clients	# Non-Ambulatory
50-65 years old	_____	_____
66-75 years old	_____	_____
76-85 years old	_____	_____
86-100 years old	_____	_____
Over 100 yrs old	_____	_____

d. Do all clients have their own attending physician? ..... **YES NO**

7. APPLICANT TRANSPORTATION

a. How are clients transported between their homes and the facility?

(i) Client is responsible for their own transportation? ..... **YES NO**

(ii) Center contracts with third party to provide transportation? ..... **YES NO**

(iii) Center provides transportation? ..... **YES NO**

b. If Center contracts with third part to provide transportation:

(i) Is the vehicle equipped with a phone or two-way radio? ..... **YES NO**

(ii) Are drivers trained in CPR and first aid? ..... **YES NO**

(iii) Are certificates of insurance obtained? ..... **YES NO**

c. If you provide transportation:

(i) Is the vehicle equipped with a phone or two-way radio? ..... **YES NO**

(ii) Are drivers' driving records checked? ..... **YES NO**

(iii) Are drivers trained in CPR and first aid? ..... **YES NO**
How often? _____

(iv) Please provide name of automobile insurance carrier and limits carried: _____

_____

8. APPLICANT STAFF

a. Have you submitted a sample employment application? ..... **YES NO**

b. Are criminal records checked for new hires? ..... **YES NO**

c. Are personal references requested and checked? ..... **YES NO**

d. Are prior employment references necessary? ..... **YES NO**

e. For each classification listed please show the number of full/part-time employees and/or independent contractors. (For part-time staff members, show the full-time equivalent.)

	Employees		Independent Contractors	
	Full-Time	Part-Time (Full-Time Equivalent)	Full-Time	Part-Time (Full-Time Equivalent)
Physicians on Staff	_____	_____	_____	_____
Physicians on Call	_____	_____	_____	_____
Dentists	_____	_____	_____	_____
Registered Nurses	_____	_____	_____	_____
Nurses Aides	_____	_____	_____	_____
Occupational/Physical Therapists	_____	_____	_____	_____
Dieticians	_____	_____	_____	_____
Beauticians/Barbers	_____	_____	_____	_____
Administrative/Clerical Personnel	_____	_____	_____	_____
Maintenance/Security Personnel	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Podiatrists	_____	_____	_____	_____
Other-describe _____	_____	_____	_____	_____
Total Number of Employees/Independent Contractors	_____	_____	_____	_____

9. APPLICANT FACILITY

a. Is the facility equipped with:

(i) At least two clearly marked exits on each floor? ..... **YES NO**

(ii) Self-closing fire doors on each floor? ..... **YES NO**

(iii) Automatic fire alarm system connected to a local fire department? ..... **YES NO**

(iv) Smoke detectors in:

(A) Common areas? ..... **YES NO**

(B) Craftroom? ..... **YES NO**

(C) Kitchen? ..... **YES NO**

(D) Sleeping Rooms? ..... **YES NO**

b. Building Description

	Buildings/Wings #1	#2	#3	#4
Type of Construction?	_____	_____	_____	_____
No. of Stories?	_____	_____	_____	_____
Total Beds?	_____	_____	_____	_____
Date Built:	_____	_____	_____	_____
Complete or Partial	_____	_____	_____	_____
Sprinkler System?	_____	_____	_____	_____

c. Evacuation procedures:

(i) Does the Center have a written emergency plan? ..... **YES NO**

(ii) Are evacuation directions posted in all parts of the Center's facility? ..... **YES NO**

(iii) Does the staff orientation plan include a review and "walk through" of any disaster plan? ..... **YES NO**

(iv) How often are evacuation/fire drills conducted?

d. Are handrails provided in hallways and bathrooms? ..... **YES NO**

e. Do you have a written patient safety policy? ..... **YES NO**
If yes, attach a copy of this policy

f. Is smoking permitted in the facility? ..... **YES NO**

10. APPLICANT HISTORY

a. Has any insurance company ever canceled, non-renewed or declined to accept your professional liability insurance? ..... **YES NO**
If Yes, please attach a detailed explanation.

b. Has the Center been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? ..... **YES NO**

c. Has the Center been the subject of any license suspension or revocation or been placed under probation? ..... **YES NO**
If Yes, please attach detailed explanation.

d. List prior professional insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form? Yes	No	Retro Date
						[ ]	[ ]	
						[ ]	[ ]	
						[ ]	[ ]	
						[ ]	[ ]	
						[ ]	[ ]	

e. List prior general insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form? Yes	No	Retro Date
						[ ]	[ ]	
						[ ]	[ ]	
						[ ]	[ ]	
						[ ]	[ ]	
						[ ]	[ ]	

11. CLAIMS

a. Has any professional liability claim or suit been brought against the Center and/or any of its employees? ... **YES** **NO**

If Yes, please submit:

(i) A fully completed Supplemental Claim Information form (SM174-2 10/92**)** for each claim or suit.

(ii) Professional liability loss experience, currently valued, from the applicant's prior professional liability insurance carrier for each of the last five (5) years.

b. Is the applicant aware of any circumstances which may result in a professional liability claim or suit being made or brought against the applicant or any of its employees? ..... **YES** **NO**
If Yes, attach a detailed explanation.

c. Has any general liability claim or suit been brought against you and/or any of your employees? ..... **YES** **NO**
If Yes, please submit:

(i) A fully completed **Supplemental claim Information** form (SM174-2 0/92) for each claim or suit.

(ii) General liability loss experience, currently valued, from your prior professional liability insurance carrier for each of the last five (5) years.

NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

Commonwealth Underwriters Ltd.

BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip

States of Licensure
New or Renewal for us

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: