Master Index

Northland INSURANCE

APPLICATION – ADULT DAY CARE

BUSINESS INFORMATION

1. Named Insured _____
2. Mailing Address _____
   Street City County State ZIP Code
3. Location of premises: ❑ Same as mailing address
   ❑ Other _____
4. Telephone ( ) _____ Fax ( ) _____
5. Contact person/phone #: Inspection _____
   Accounting/Records _____
6. Business type: ❑ Individual ❑ Partnership ❑ Corporation ❑ LLC
   ❑ Trust ❑ Other _____
7. Operating as: ❑ For Profit ❑ Nonprofit ❑ Other _____
8. Interest of Named Insured in premises: ❑ Owner ❑ General Lessee ❑ Tenant ❑ Other _____
9. Part occupied by Named Insured: ❑ Entire ❑ Portion(____%) ❑ Other (Lessor's Risk Only)
10. Date business established _____

DESIRED TERMS AND CONDITIONS

1. Coverage desired: ❑ General Liability ❑ Professional Liability
2. Limit of Liability Desired: ❑ $100,000/$300,000 ❑ $300,000/$600,000 ❑ $500,000/$1,000,000
   ❑ $1,000,000/$1,000,000 ❑ Other _____
3. Physical/Sexual Abuse: ❑ $25,000/$50,000 ❑ $50,000/$100,000 ❑ $100,000/$300,000

   Note: Standard coverage includes the following:

Damage to Premises Rented to You	$100,000
Medical Payments	$5,000
Personal and Advertising Injury	Same as Occurrence Limit

4. Contractual Liability: ❑ (Attach copy of contract) No separate limit
5. Effective Date Desired _____ Term Desired _____

TYPE OF FIRM

1. Type of day care: ❑ Social – provides non-medical care to adults in need of personal care services only
   ❑ Health (may include Social) – provides health, social, rehabilitative and mental health needs
   ❑ Other _____
2. Description of operations. _____
   _____

PREMISES

1. Age of building _____
2. Construction _____
3. Number of floors _____
4. Total square footage _____
5. Number of exits _____

	Yes	No
6. Central station alarm	❑	❑
7. Emergency lighting	❑	❑
8. Fully sprinklered	❑	❑

If no, describe extent of sprinklering:
_____
_____

Last update: Wiring _____ Plumbing _____

	Yes	No
10. Smoke detectors in: All rooms	❑	❑
Halls	❑	❑
11. Are there any swimming pools?	❑	❑
12. Has emergency evacuation plan been prepared?	❑	❑
13. Are both scheduled and unscheduled fire and emergency drills conducted?	❑	❑
14. Are emergency facilities readily available?	❑	❑

If yes, describe. _____

OPERATIONS

1. Does your facility provide: Physical therapy ❑ Yes ❑ No
   Medication services ❑ Yes ❑ No
2. Describe all services and activities provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report*.
   _____
3. Number of participants: ❑ Social Care _____ ❑ Health Care _____
4. Participant age groups (# for each): Under 18 Years_____ 18-65 Years _____ Over 65 Years _____

	Yes	No
5. Are there procedures in place for participant screening and acceptance?	❑	❑
6. Are current records and files maintained on each participant?	❑	❑
7. Have any participants been diagnosed with Alzheimer's?	❑	❑

If yes, how many at the following stages:Stage 1 _____ All other stages _____

8. Have any participants been diagnosed with a mental illness?	❑	❑

9. Number of participants not capable of taking action for self-preservation _____
   Number of participants capable of taking action for self-preservation _____

10. Any non-ambulatory patients above the second floor?	❑	❑

_____

11. Is there a record keeping system in place that documents: Operational procedures	❑	❑
Incidents	❑	❑

12. Describe duties of volunteers or students._____
13. Additional insureds (state their interests in insured's operation). _____
14. Total all locations: Receipts $ _____
15. How are funds obtained? (i.e. Medicare, donations, fees, government grant, etc.)_____

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? ❑ Yes ❑ No
2.

Staff	Total Number	Staff	Total Number
Nurse Practitioners		Recreational Therapists	
RN/LPN/LVNs		Social Workers	
Psychologists		Aides/Homemakers	
Physical Therapists		Counselors	
Occupational Therapists		Other (define)	

	Yes	No
a. Are all staff certified/licensed according to federal, state, or local requirements?	❑	❑
b. Are any staff working on a contract basis?	❑	❑
If yes, do you require proof of separate professional liability insurance?	❑	❑

3. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:

	None	Written	Verbal
a. Educational background or residency program check, when applicable.	❑	❑	❑
b. Previous employers check.	❑	❑	❑
c. Personal references check.	❑	❑	❑
d. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals.	❑	❑	❑
e. Criminal background check.	❑	❑	❑

Are copies of background checks kept on file? ❑ Yes ❑ No

EDUCATION, LICENSING, ACCREDITATION

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility?
❑ Yes ❑ No ❑ No licensing requirements
If no, state reasons for non-compliance and corrective action taken.

_____

_____

Have you had any licensing or code violations in the past three years? ❑ Yes ❑ No
If yes, describe. _____

_____

Does state licensing differentiate participant's ability for self preservation in the event of an emergency?
❑ Yes ❑ No

2. Is the facility accredited by any governmental or other body?
❑ Yes ❑ No ❑ No accreditation available
If yes, describe. _____
3. Are you a member of any professional association or organization? ❑ Yes ❑ No
Name of association or organization. _____

RISK MANAGEMENT

	Yes	No
1. Do you have a formal written risk management program?	❑	❑
2. Is there a designated risk management person?	❑	❑
If no, how are these duties delegated? _____		
3. Do you have a written requirement that health care professionals providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage?	❑	❑
4. Do you have: a. Written job descriptions	❑	❑
b. Policies and/or procedures manual	❑	❑
c. Full-time administrator or medical director on staff	❑	❑
d. Formalized loss control and claim prevention training program	❑	❑
e. Emergency shelter arrangements for participants	❑	❑
5. Have you entered into any other contractual agreements?	❑	❑
a. If yes, is legal advice sought to write and approve?	❑	❑
b. Does the agreement require you to hold any third party harmless?	❑	❑

PREVIOUS EXPERIENCE

1. Describe management's/administrator's education and experience. _____

_____

2. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities? **Yes** ❑ **No** ❑

   If yes, explain. _____

   _____

3. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**
   Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years? *If yes, give name of company, date and reason.* _____ ❑ ❑

_____

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS					
Year	**Carrier**	**Policy Number**	**Coverage**	**Check if Claims-Made**	**Premium**
				❑	
				❑	
				❑	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

_____

Signature of Applicant | Title | Date

_____

Signature of Producing Agent | Date

_____

Agent Name and Address