

ADULT DAY CARE APPLICATION

Applicant Name _____

Mailing Address _____

City/State/Zip _____

Location Address _____

City/State/Zip _____

Effective Date _____

Years in business _____

Form of Business Individual Partnership Corporation Non-Profit Organization

Where is the business located? Commercial building Private residence

A. Commercial General Liability

1. Limits of Liability Requested:

General Liability 100/200 100/300 300/300 300/600 500/500 500/1Mil 1Mil/1Mil 1Mil/2Mil

B. Commercial Property (Optional):

1. a. Is property prohibited in our Coastal Guidelines? (If yes, decline property.) Yes No

b. Cause of loss Basic Broad Special

c. Property deductible 1,000 2,500 5,000 Other _____

2. Building Construction _____ Protection Class _____ Area _____ Sq. Ft.

Building Age _____ Year of update to: Roof _____ Heating _____ Plumbing _____ Electric _____

3. Coverage Desired:

Limit	Building	&	Business	Personal
Property				

Building (No residential bldgs.): _____ RC ACV **Coinsurance** 80 90 100

Bus. Personal Property _____ RC ACV

Business Income _____ 50 60 70 80 90 100 125 or 1/3 1/4 1/6

4. List any loss payees or mortgagees to be added. _____

C.

1. Is the applicant a licensed commercial Adult Day Care Provider? No Yes

2. State license number _____ Years at this location _____

3. Maximum number of clients permitted by license _____ On site at any given time _____

4. Indicate client to supervisor ratio _____

5. Number of full time staff _____ Number of part time staff _____

6. Describe any specialized care given (Handicapped, Deaf, Invalid, etc.). _____

7. What are the days and hours of operation? _____
8. Are meals served? No Yes If yes, _____% prepackaged _____% cooked
9. What type of cooking equipment? _____
10. Type of fire protection for cooking equipment _____
11. If Ansul system, how often serviced? _____
12. Number of rooms in facility _____ Number of exits on each floor _____
13. Number and location of smoke detectors _____
14. How often does the insured schedule trips off premises? _____
15. How often, to where and farthest distance? _____
16. Describe type of background checks on all employees and volunteers? (Note if "none.") _____

17. Please describe all the activities at this facility. _____

18. Indicate type of facility: Social Medical Mental
19. Indicate type of housing, if any provided: Social Medical Mental
20. Is this an in home facility? Yes No If yes, please explain. _____

21. Is there a swimming pool on the premises? Yes No If yes, is it fenced? Yes No
22. Describe any special equipment on premises. _____

23. Are there any non-ambulatory attendees? Yes No If yes, how many? _____
24. Are there any Alzheimer's afflicted adults? Yes No If yes, how many? _____
25. Are there any protective measures in place to prevent Alzheimer's afflicted adults from wandering? Yes No
If yes, describe. _____

26. Describe how injuries or illnesses are handled. _____

27. Is there a doctor or staff or call? Yes No If yes, please explain. _____

28. Is there any overnight exposure? Yes No
29. Is there any physical therapy exposure at this facility? Yes No

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

31. Submit details of any loss in the last 5 years. _____

Applicant Signature & Date

Producer Name & Address

NOTICE OF INSURANCE INFORMATION PRACTICES

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTION ON HOW TO SUBMIT A REQUEST TO US.

COVERAGE NOT BOUND UNTIL APPROVED BY THE COMPANY.