Surplus Insurance Brokers Agency Inc.

Call 800-342-5706
Fax 800-578-7758 ▪ www.surplusins.com
Email quotes: submit@surplusins.com
P O Box 749, South Bend IN 46624-0749

ADULT DAY CARE APPLICATION

1. Proposed First Named Insured & Other Named Insured(s):

2. Mailing Address — Street — City — County — State — ZIP Code

3. Location Address — Street — City — County — State — ZIP Code

4. Telephone: — Fax:

5. Contact person/phone #: Inspection:
   Accounting/Records:

6. Policy Period Desired: From: — To:

BUSINESS INFORMATION

1. Business Type: ☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ Trust
   ☐ Other (specify):
2. Date Business Established:
3. Operating as: ☐ For Profit ☐ Nonprofit ☐ Other:
4. Interest of Applicant in Premises: ☐ Owner ☐ General Lessee ☐ Tenant
   ☐ Other:
5. Part Occupied by Applicant: ☐ Entire Building ☐ Portion (_____%)
   ☐ Other (Lessor's Risk Only)

COVERAGE/LIMITS

1. Coverage Desired: ☐ General Liability ☐ Professional Liability
2. Liability Limits 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. Abuse/Molestation: ☐ $100,000/$300,000 ☐ $300,000/$600,000
   ☐ $500,000/$1,000,000 ☐ $1,000,000/$1,000,000

   (Complete Abuse/Molestation Suppl.)
5. Contractual Liability: ☐ (Attach copy of contract) No separate limit

TYPE OF FIRM / OPERATIONS

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:
3. Does your facility provide: Physical Therapy ☐ Yes ☐ No
   Medication Services ☐ Yes ☐ No
4. 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.*

5. Number of participants: — Social Care: — Health Care:

6. Number of participants in each age group:

Under 18 Years:	18-65 Years:	Over 65 Years:

		Yes	No
7.	Are there procedures in place for participant screening and acceptance?	☐	☐
8.	Are current records and files maintained on each participant?	☐	☐
9.	Have any participants been diagnosed with a mental illness?	☐	☐
10.	Have any participants been diagnosed with Parkinson's Disease, Huntington's Disease, stroke, etc.?	☐	☐
11.	Have any participants been diagnosed with Alzheimer's?	☐	☐

If yes, how many in the following stages: Stage 1: All other Stages:

12. Do you provide any of the following services:	Yes	No
a. Shock Therapy	☐	☐
b. Restraints	☐	☐
c. Sedation	☐	☐
d. Respite Care	☐	☐
e. Experimental Treatments	☐	☐
f. Diagnosis of Illness or Prescription of Medication	☐	☐

13. Hours participants are on the premises:				
	Monday - Friday	a.m.	to	p.m.
	Weekends	a.m.	to	p.m.

14. Do you ever provide any over-night care? ☐ Yes ☐ No

15. Do you provide any off-premises care? ☐ Yes ☐ No

16. Number of participants not capable of taking action for self-preservation:

17. Number of participants capable of taking action for self-preservation:

	Yes	No
18. Any non-ambulatory patients above the second floor?	☐	☐
19. Is there a recordkeeping system in place documenting:		
a. Operational Procedures	☐	☐
b. Incidents	☐	☐
c. Medical Treatment	☐	☐
d. Dispensing of Prescribed Medications	☐	☐
e. Illness	☐	☐
f. Notification to Family	☐	☐

	Yes	No
20. Are there written procedures in place regarding abuse and molestation?	☐	☐
a. Are the procedures communicated to and reviewed with staff and volunteers?	☐	☐
b. Are there procedures in place for reporting incidents?	☐	☐
c. Are all incidents reported to your insurer?	☐	☐

21. Describe duties of volunteers and students:

22. Additional insureds (state their interests in insured's operation):

23. Total all locations: Receipts $

24. Indicate how funds are obtained (i.e. Medicare, donations, fees, government grant, etc.):

PREMISES

1. Age of Building: | Construction:
2. Number of Floors: | Total Sq. Footage: | Number of Exits:

		Yes	No
3.	Central Station Alarm?	☐	☐
	Emergency Lighting?	☐	☐
	Fully Sprinklered?	☐	☐

If no, describe extent of sprinklering:

4. Last update: | Wiring: | Plumbing:

			Yes	No
5.	Smoke detectors in:	All Rooms	☐	☐
		Halls	☐	☐
6.	Fire Extinguishers		☐	☐
7.	Is the business located in a mobile home?		☐	☐

8. Frequency premises inspected: | Date of last inspection:
By whom:

		Yes	No
9.	Are there any swimming pools or water hazards on the property or in close proximity?	☐	☐
10.	Has an emergency evacuation plan been prepared?	☐	☐
11.	Are both scheduled and unscheduled fire and emergency drills conducted?	☐	☐
12.	Are emergency facilities readily available?	☐	☐

If yes, describe:

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
3.	Are all staff certified/licensed according to federal, state, or local requirements?	☐	☐
4.	Does any staff work on a contract basis?	☐	☐
	If yes, do you require proof of separate professional liability insurance?	☐	☐

5. 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	☐	☐	☐

f. 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:
2. Have you had any licensing or code violations in the past three years? ☐ Yes ☐ No
   If yes, describe:
3. Does state licensing differentiate participant's ability for self preservation in the event of an emergency?
   ☐ Yes ☐ No
4. Is the facility accredited by any governmental or other body? ☐ Yes ☐ No ☐ No accreditation available
   If yes, describe:
5. 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, describe how duties are 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?	☐	☐
	If yes, is legal advice sought to write and approve?	☐	☐
6.	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 (owners) 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:

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS

Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				☐	
				☐	
				☐	

Missouri Applicants: **DO NOT** answer this question.
Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?
☐ No ☐ Yes - If Yes, give name of company, date, and reason.

Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years. *Attach separate sheet if necessary.*

Dates (Month/Year)	Allegations	Amount	Paid	Reserve
			☐	
			☐	
			☐	

FRAUD STATEMENTS

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.

LOUISIANA and 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 include imprisonment, fines, and denial of insurance benefits.

Refer to the Core Application for all Fraud Statements.

IMPORTANT NOTICE

DECLARATION

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

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

SIGNATURES

Applicant Signature	Title	Date
Producer Signature		Date
Producer Name and Address		

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ABUSE/MOLESTATION SUPPLEMENT

Named and Address of Insured: | Date:

Operating As:
☐ For Profit ☐ Nonprofit ☐ Other:

Account Type (Describe Your Primary Business):

Check all operations that apply:
Primary refers to your predominant operation that generates most of your sales, payroll, receipts, admissions, income, or operating revenues.
Ancillary refers to any activities that are incidental to your primary operation.

Operation	Primary	Ancillary
Ambulance Service	☐	☐
Assisted Living Facility	☐	☐
Building Owner	☐	☐
Bus Company	☐	☐
Camp **Answer question 1 on page 2**	☐	☐
Club-civic, service, social	☐	☐
Club-country or golf	☐	☐
Club-exercise or health	☐	☐
College/University **Answer question 2 on page 2**	☐	☐
Convalescent Home/Nursing Home	☐	☐
Day Care Center-Adult or Child **Answer question 3 on page 2**	☐	☐
Healthcare facility (incl. Home Health Care)	☐	☐
Medical Office (including Dental)	☐	☐
School K-12 **Answer question 4 on page 2**	☐	☐
School-Miscellaneous **Answer question 5 on page 2**	☐	☐
Seminary	☐	☐
Shelter, Mission, Settlement, or Halfway House	☐	☐
Social Service Agency **Answer question 6 on page 2**	☐	☐
Store	☐	☐
YMCA/YWCA	☐	☐
Youth Recreation programs including Boy/Girl Scouts **Answer question 7 on page 2**	☐	☐

Other Custodial Operation (Explain):
Examples: Babysitting service, supervised play area, supervised children's programs/activities, youth sports clinic, and other similar operations.

Additional Questions (Answer only if applicable to your operations)

1. **Camp Operations**
   Type of Camp: Number of days camp is operational (annually):
   Number of Camp Locations: ☐ Day ☐ Night
2. **Colleges/Universities**
   Total undergraduate student enrollment: Percentage of Boarding Students %
   Fraternities or Sororities? ☐ Yes ☐ No
3. **Day Care - Adult or Child**
   Total number of attendees:

Age of Attendees	Average Daily Attendance
Under 2 years	
2 to 5 years	
6 to 17 years	
18 to 60 years	
60 years +	

4. **Schools K-12**

Total student enrollment: Percentage of Boarding Students: %

5. **Schools - Miscellaneous**

Describe your operations:

6. **Social Service Agencies**

List/describe the types of social services offered:

7. **Youth Recreation programs including Boy or Girl Scouts**

Total registrant enrollment:

Subcontracted Custodial Operations

Do you hire or use subcontractors for any custodial operations? ☐ Yes ☐ No

Do you require that those subcontractors name you as an additional insured? ☐ Yes ☐ No

Do you require those subcontractors to provide a Certificate of Insurance showing Abuse or Molestation coverage with limits of at least $1,000,000? ☐ Yes ☐ No

Number and Types of Clients/Students in your Custody

Client/student Description	Approximate Total Number
Persons under the age of 18	
Persons who are physically or mentally impaired/handicapped	

How long is a client/student normally associated with your organization?

Licensing/Regulatory Requirements

1. Is licensing required for your custodial operation? ☐ Yes ☐ No

   If yes, is your license current? ☐ Yes ☐ No

   If no, explain:

   If yes, has your license ever been suspended or revoked? (Not Applicable in Missouri) ☐ Yes ☐ No

   If yes, explain:

2. Are there local/state/federal regulatory requirements for your custodial operations? ☐ Yes ☐ No

3. Do your custodial business operations meet or exceed all applicable state or local regulatory requirements?

   ☐ Yes ☐ No If no, explain in detail:

4. Has there ever been an investigation of your operations by any public authority relating to abuse or molestation?

   ☐ Yes ☐ No If yes, explain in detail:

Incident and Claim History

Describe **any** Abuse or Molestation Incidents/Losses/Claims

Date of Incident	Description	Loss Amount	Open/Closed

Volunteers

Do you utilize volunteers? ☐ Yes ☐ No

If yes, percentage of your current staff that are volunteers: %

If yes, describe fully any volunteer activities:

Location

Where do interactions with clients/students take place? (Check all that apply)

☐ Public Areas ☐ Private Offices ☐ Remote Locations

☐ School Facilities ☐ Private Homes ☐ Camp Grounds

☐ Other - Describe:

Which of the following controls do you have in place to prevent the potential for abuse or molestation?

Windowed rooms ☐ Yes ☐ No

Windowed doors ☐ Yes ☐ No

Open Viewing areas which prevent a single employee/volunteer from routinely being alone with a client/student AND out of view from other employees/volunteers? ☐ Yes ☐ No

Describe any area of your facilities which would allow an employee or volunteer to be alone with a client/student.

Does your facility have security patrols or closed circuit monitors of client/student areas? ☐ Yes ☐ No

Are children separated from all adults other than employees and volunteers who are responsible for their care and supervision (e.g. janitorial, food service, maintenance, suppliers, vendors, visitors, customers, or other adults that may be on, or have access to your premises)? ☐ Yes ☐ No

Foreign Exposures

Describe any client/student activities, sponsored by you, that take place outside of the United States.

For activities outside the U.S., clients/students are chaperoned by:

☐ Employees ☐ Volunteers ☐ Parents ☐ Not Chaperoned

☐ Other (Describe):

Parent/Family Involvement

Indicate the parent or family member involvement in your activities:

☐ Routine, ongoing involvement of parents or family members

☐ Occasional parental/family involvement ☐ No or almost no parental/family involvement

Employee/Volunteer Interaction with Clients/Students

Describe all positions involving adult-minor interaction (e.g. Teacher-Student, Coach-Athlete, Counselor-Client/Student, etc.):

Level of Adult Supervision

Indicate the level of your employee/volunteer supervision of activities with clients/students:

☐ Single employee works alone with clients/students

☐ Single volunteer works alone with client/students

If either of the above two boxes are checked, explain in detail why such one-on-one activities/interfaces are necessary as part of your operations/activities, e.g. counseling, therapy, etc.

☐ Single employee/volunteer alone with multiple clients/students

☐ Two or more employees or volunteers are present with clients/students

Personal Activities

Which personal activities do your employees/volunteers assist clients/students:

☐ Normally no assistance with personal activities

☐ Bathing, toileting, or changing clothes

☐ Other (Describe):

Employee/Volunteer Hiring or Selection Procedures

	Question	Employees Yes	Employees No	Volunteers Yes	Volunteers No
1.	Do you require a written application for all employees and volunteers?	☐	☐	☐	☐
2.	Do applications require the applicant's signature and include a warning that untruthful answers are grounds for non-employment or dismissal?	☐	☐	☐	☐
3.	Do applications include questions concerning any prior abuse or molestation allegations, incidents, convictions, or pleadings of guilty or "no contest" to a misdemeanor or felony?	☐	☐	☐	☐
4.	Does the application include an acknowledgement that a background check may be conducted?	☐	☐	☐	☐
5.	Do you perform documented reference checks including criminal records background checks on a state and federal level on all employees who have contact with clients/students, including janitorial staff, and all volunteers? Explain any exceptions.	☐	☐	☐	☐
6.	Do you maintain the practice of turning down new employees with prior sexual/physical abuse or molestation allegations against them?	☐	☐	☐	☐
7.	Do you screen employees/volunteers for drug use?	☐	☐	☐	☐
8.	Do you use any form of psychological profiling or abuse screening techniques?	☐	☐	☐	☐

Background Checks

	Question	Employees		Volunteers	
1.	Have background checks been conducted on all current employees/volunteers?	☐ Local ☐ Federal	☐ No ☐ No	☐ Local ☐ Federal	☐ No ☐ No
2.	Do you conduct criminal background checks as a hiring requirement for new employees/volunteers?	☐ Local ☐ Federal	☐ No ☐ No	☐ Local ☐ Federal	☐ No ☐ No
3.	Do you conduct follow-up background checks in accordance with state/local requirements or at a minimum of every five years?	☐ Local ☐ Federal	☐ No ☐ No	☐ Local ☐ Federal	☐ No ☐ No

4. How often do you obtain background checks? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5 yrs.
5. Do you perform qualification or credential checks on all professional staff including teachers? ☐ Yes ☐ No

Policies/Procedures for Prevention of Abuse or Molestation

	Question	Yes	No
1.	Do you have written policies and procedures for the prevention of abuse/molestation?	☐	☐
2.	**Does your written procedures manual:**		
a.	Outline your organization's commitment to child safety and the safety of any other persons in your custody?	☐	☐
b.	Establish a child/victim group protection policy with assigned responsibilities and accountabilities?	☐	☐
c.	Contain procedures for the immediate and proper handling of sexual or other abuse allegations?	☐	☐
3.	**For Youth Services Organizations (e.g. primary schools, youth recreation organizations, camps, day cares)** Restrict "one on one" situations between employee/volunteer and clients/students?	☐	☐
4.	Establish that child care staff must adhere to the "*three person rule"?	☐	☐
	**This rule prevents an adult from being alone with one youth. A second adult must be present, or there must be two or more youth with an adult.*	☐	☐
5.	Establish if and when exceptions to the "three person rule" are permissible as part of your operations/activities?	☐	☐
6.	Prohibit corporal punishment?	☐	☐
7.	Require that written procedures are publicly displayed?	☐	☐
8.	Indicate that anyone suspected of an abuse/molestation offense will be subject to civil or criminal prosecution to the fullest extent allowed by law?	☐	☐

Are the following rules/practices enforced?	**Yes**	**No**
1. Transportation done by two adults or has very strict time and routes enforced.	☐	☐
2. Required prior establishment of those persons allowed to visit/pickup clients/students.	☐	☐
3. Overnight activities are clearly planned and approved by management? (Adequate number of pre-approved employees/volunteers and no single adult/child shared sleeping accommodations.)	☐	☐
4. Off premises activities are only done with 2 or more prepared staff/volunteers.	☐	☐
5. Encouragement of unannounced parental visits and program involvement.	☐	☐
6. A buddy system in place for children.		

Abuse or Molestation Training

Describe your abuse or molestation prevention training (check)

	None	Orientation	Formal Training	Records Kept
Employees	☐	☐	☐	☐
Volunteers	☐	☐	☐	☐

Do your employee/volunteer training procedures:	**Yes**	**No**
1. Have a documented orientation program in place that clearly indicates "zero tolerance" of any type of abuse or molestation to the child/victim group and outlines what action will be taken in the event of any such abuse or molestation?	☐	☐
2. Include training in the recognition of sexual/physical abuse symptoms and include procedures to follow if a peer is suspected of such abuse?	☐	☐
3. Have a probationary period in place with close observation of all new employees/volunteers?	☐	☐
4. Periodically schedule refresher training for all employees/volunteers?	☐	☐
5. Document all training for content and frequency?	☐	☐

Client/Student Abuse or Molestation Training

1. Do you conduct abuse or molestation awareness training for clients/students? ☐ Yes ☐ No
2. Do you keep records of clients/students abuse or molestation awareness training? ☐ Yes ☐ No

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SIGNATURES

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Producer Signature		Date
Producer Name and Address		