

Jackson Sumner & Associates

Excess and Specialty Lines Broker

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Halfway House General Liability and Professional Liability Application

Applicant Name: _____ Agent Name: _____

Mailing Address: _____ Address: _____

Location: _____ Proposed Effective Date: _____

From _____ to _____

Applicant is: Individual Corporation Partnership Joint Venture

Other (Specify) _____

LIMITS OF LIABILITY REQUESTED

General Aggregate \$ _____

Products & Completed Operations Aggregate \$ _____

Personal & Advertising Injury \$ _____

Each Occurrence \$ _____

Fire Damage (any one fire) \$ _____

Medical Expense (any one person) \$ _____

Professional Liability Each Occurrence \$ _____

Aggregate \$ _____

Sexual and/or Physical Abuse:

\$25,000/\$50,000

\$50,000/\$50,000

Deductible: \$ _____

1. Applicant operates as: Profit Nonprofit Number of years in operation: _____

2. How long under present management? _____ (If fewer than five years, attach principals' resumes. If principals in the firm do not have a health care background, then also include the resume of the individual responsible for hiring, screening and monitoring the work activities of your employees.)

3. Type of operation:

Outpatient aftercare and support program (AA, Al-Anon, etc.)

Outpatient counseling or guidance center

Crisis centers (rape, domestic violence, etc.)

Non-medical drug and alcohol rehabilitation center

Homeless shelters

Mission or settlement house

Describe type of operation and services provided (attach brochure and/or advertising material if available):

4. Operations conducted in the following states:
State: _____ Licensed with state? Yes No License # _____
State: _____ Licensed with state? Yes No License # _____
State: _____ Licensed with state? Yes No License # _____

5. Has license ever been revoked? Yes No If yes, explain: _____

6. Name all subsidiary companies/locations and others coming under applicant's control (if none, please state):

7. Has the applicant sold, acquired or discontinued any operations in the last five years? Yes No
If yes, please explain: _____

8. Is at least one of the principals or an Administrator/Director involved in the operation on a full-time basis?
 Yes No

9. Physical features of risk:
a. Construction of building: _____
b. Number of floors: _____ On which floor is applicant located? _____
Square foot area occupied by the applicant: _____
c. Year built: _____
d. Equipped with sprinkler system? Yes No
Equipped with fire alarm? Yes No Central Station Local Alarm
Equipped with smoke detectors? Yes No How many on each floor? _____
e. Number of fire extinguishers on premises: _____ Number of fire escapes: _____
f. Is smoking allowed on premises? Yes No If yes, where is it permitted? _____
g. Is there a swimming pool, hot tub/spa on premises? Yes No

10. Emergency procedures:
a. Do you have a written Emergency Evacuation Plan? Yes No
b. Does your plan include advance agreement of transportation and temporary shelter? Yes No
c. Are evacuation procedures posted in all parts of your facility? Yes No
d. How often are drills conducted? _____

11. State patient's/resident's ages from: _____ (youngest) to _____ (oldest)
Average age: _____

12. Physicians, if any, are:
 Private practitioners (independent contractors)
 Employees of the applicant
 Contracted physicians through written contract with applicant
If contracted physician, are certificates (evidence) of professional liability insurance required and kept on file?
 Yes No

13. Do services provided include Infusion Therapy? Yes No

Does treatment process involve the administration of methadone or ether drops? Yes No

14. Are employees authorized to use their personal vehicles to transport residents or patients? Yes No

15. Are residents/patients placed in applicant's facility by court order? Yes No

16. Any involvement in medical detoxification? Yes No

17. Does facility accept prisoners on work release or rehabilitation programs? Yes No

18. Does facility provide pregnancy and/or abortion counseling services? Yes No

19. Does facility, if an inpatient facility, accept children under the age of 18? Yes No

If yes, does applicant also require the child's guardian to be in residence at the same facility? Yes No

20. Is facility a foster home or foster care facility? Yes No

21. Does facility provide inpatient services for either of the following:

a. Developmentally Disabled-Adults or children able to care for themselves despite their disability or mental retardation. Examples of this category include Downs Syndrome, autism, and brain injuries. This category does not include individuals whose primary diagnosis is an emotional or mental illness. Yes No

b. Mentally Disabled-Adults or children able to care for themselves (with substantial numbers able to hold jobs). Behavior is controlled through medication and monitored by their personal physician. This category would include individuals whose primary diagnosis is an emotional or mental illness including but not limited to schizophrenia, psychopathic and sociopathic diagnosis. Yes No

22. Does the applicant provide bed and board facilities? Yes No If yes, number of beds: _____

Length of stay: from _____ (shortest) to _____ (longest) Average: _____

23. Does the applicant provide outpatient services? Yes No

If yes, number of annual outpatient visits: _____

24. Explain arrangement for medical emergencies (i.e., M.D. on call, transfer arrangements with hospital, etc.):

25. As part of hiring/screening of new employees, does applicant:

a. Obtain copies of their professional licenses/certifications? Yes No

b. Contract applicants' references before they are hired? Yes No

c. Require that they carry their own professional liability policy? Yes No

26. Does applicant have Workers' Compensation coverage in force? Yes No

27. Does applicant lease employees? Yes No

28. Does applicant have any contractual agreements wherein applicant assumes the liability of others?

Yes No

If yes, please attach a list of each entity that has requested to be named as an additional insured and the type of service(s) applicant provides.

29. Any other premises or operations exposures not stated in this application? Yes No

If yes, attach a complete description and underwriting/rating information.

Schedule of Hazards

Loc. No.	Classification	Class Code	Premium Basis: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate	Premium

30. During the past five years, have any claims been made or suit brought against the applicant because of alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation?

Yes No

If yes, date: _____ Please explain: _____

31. During the past three years, has any company cancelled, declined, or refused similar insurance to the applicant? Yes No

If yes, explain: _____

Previous Insurer: Indicate premium and losses for past three years. Describe all losses.

Year	Company	Pol#	Occurrence or Claims Made	Premium	Losses Paid	Losses Reserved	Description

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

Name and Title _____

Applicant's Signature _____ Date _____

Name and Phone Number of individual to contact for inspection/audit
