APPLICATION – ADULT DAY CARE – SUPPLEMENT

BUSINESS INFORMATION

1. Named Insured: ____________________________________________________________
2. Telephone (   ) __________________ Fax (   ) __________________
3. Contact person/phone #: Inspection ___________________________
   Accounting/Records ____________________________
4. Operating as:  ⚡ For Profit ⚡ Nonprofit ⚡ Other
5. Interest of Named Insured in premises:  ⚡ Owner ⚡ General Lessee ⚡ Tenant ⚡ Other
6. Part occupied by Named Insured:  ⚡ Entire ⚡ Portion( %) ⚡ Other (Lessor’s Risk Only)
7. Date business established: _______________

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Station Alarm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency lighting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully sprinklered If no, describe extent of building sprinkled:</td>
<td></td>
<td></td>
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<tr>
<td>Smoke detectors in: All rooms Halls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any swimming pools?</td>
<td></td>
<td></td>
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<tr>
<td>Has emergency evacuation plan been prepared?</td>
<td></td>
<td></td>
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<tr>
<td>Are both scheduled and unscheduled fire and emergency drills conducted?</td>
<td></td>
<td></td>
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<tr>
<td>Are emergency facilities readily available?</td>
<td></td>
<td></td>
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<tr>
<td>Construction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of floors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total square footage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of exits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of building</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last update: Wiring Plumbing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
3. Number of participants:  ⚡ Social Care ⚡ Health Care
4. Participant age groups (# for each): Under 18 Years 18-65 Years Over 65 Years

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are there procedures in place for participant screening and acceptance?</td>
<td></td>
<td></td>
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<tr>
<td>Are current records and files maintained on each participant?</td>
<td></td>
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</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Staff</th>
<th>Total Number</th>
<th>Staff</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioners</td>
<td></td>
<td>Recreational Therapists</td>
<td></td>
</tr>
<tr>
<td>RN/LPN/LVNs</td>
<td></td>
<td>Social Workers</td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td></td>
<td>Aides/Homemakers</td>
<td></td>
</tr>
<tr>
<td>Physical Therapists</td>
<td></td>
<td>Counselors</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td></td>
<td>Other (define)</td>
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</table>

2. Are all staff certified/licensed according to federal, state, or local requirements?  .
3. Are any staff working on a contract basis?  .
   If yes, do you require proof of separate professional liability insurance?  .
4. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:
   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. ____________________________________________________________

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
Is the facility accredited by any governmental or other body?  Yes, No, No accreditation available. If yes, describe. 

4. Are you a member of any professional association or organization?  Yes, No, No accreditation available

5. 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?  Yes, No

   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? Yes, No

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?  Yes, No

   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

Yes  No

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 non-renewed 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Carrier</th>
<th>Policy Number</th>
<th>Coverage</th>
<th>Check if Claims-Made</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
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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 __________________________________________________________

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