



Western World Supplemental Application

1. Applicant Name: Street: City: State: Zip: Website:

2. Form of Business: Individual Corporation Partnership Non-Profit Corp. Professional Assn Other:

3. Contact for inspection: Agent: Phone number: Agent's phone number:

4. Date established:

5. Limits of Insurance requested: \$ General Aggregate Limit (other than products-completed operations) \$ Products-Completed Operations Aggregate Limit \$ Personal and Advertising Injury Limit \$ Each Occurrence Limit \$ Fire Damage Limit - any one (1) fire (up to \$50,000 limit available) \$ Medical Expense Limit - any one (1) person (up to \$5,000 limit available) \$ Each Professional Incident Limit (if applicable)

6. Effective dates desired: From to

7. Prior insurance carrier and loss history: If new venture, check here:

Table with 6 columns: Insurance Company, Policy Period, Limits of Liab, Premium, Occurrence or Claims Made, Losses (attach details)

8. Is applicant engaged in, owned by, associated with or involved with any other enterprises? Yes No If yes, explain:

9. Are you licensed by the State? License capacity: Yes No If yes, license #: Expiration of license: Has licensed ever been revoked or suspended? Yes No

10. Maximum number of clients on premises at one time? Average daily attendance? Please describe daily activities:



Adult Day Care application for applicant: _____

Any overnight stays? If yes, attach details. Yes No

11. Transportation provided? Own vehicles Contracted vehicles Yes No
If yes, describe: _____

12. Indicate type of facility: Social Medical/Mental
Describe: _____

13. How many non-ambulatory clients are there? _____ On what floor are they? _____
How many Alzheimer's-afflicted clients? _____ How many medical/mental clients? _____
How many over 65 but mentally and physically fully functional? _____
Staff-to-client ratio? _____ to _____
Describe how injuries or illness are handled: _____

14. List medications administered and in what form given: _____
Given under prescription of MD? _____
Any medical treatment provided? If yes, describe: Yes No

15. Any counseling therapy provided? If yes, describe: Yes No

16. Is this an in-home facility? If yes, describe premises arrangements for clients: Yes No

17. Describe nature and frequency of off-premises field trips: _____
What is staff-to-client ratio during excursions? _____ to _____

18. Describe building, including age, construction, alarms and sprinklers: _____
floors: _____ stairs: _____ elevators: _____
Is applicant responsible for maintenance? Yes No
Is there a written emergency evacuation plan in place? Yes No

18. a. Is there as swimming pool? Yes No
How often used? _____ How deep is water? _____
What safety equipment is provided? _____
How supervised? _____

19. Patient breakdown by age group: 18-35 years _____ 51-65 years _____
36-50 years _____ over 65 yrs _____



Adult Day Care application for applicant: _____

20. What precautions are taken to keep track of clients? _____
Sign out procedures? Yes No Alarms on doors? Yes No
Other - please describe: _____

21. Indicate number of each type of employee:
_____ A MDs _____ E Psychologists _____ H Podiatrist
_____ B RNs _____ F Therapists _____ I Dentist
_____ C LPNs _____ G Counselors _____ J Other: _____
_____ D Nurses Aides

22. Who of the above employees are required to maintain their own professional liability insurance coverage?
Limits required? _____ Certificates required? Yes No

23. How are employees screened? _____

24. What other services, such as beauty, podiatry or dental, are provided either by staff or by independent contractors?

25. Do you require certificates of insurance from all contracted professionals? Yes No
What limits do you require? _____

26. Is applicant, or any other persons for whom coverage is being requested, aware of any circumstances which may result in a claim? If yes, provide details: Yes No

27. Has applicant, or any other person for whom coverage is being requested, had any liability application denied, policy cancelled or policy not renewed in the past three (3) years? Yes No
If yes, explain: _____

For Sexual Molestation Coverage (optional), complete questions 28 through 32.

28. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? If yes, explain: Yes No

29. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? If yes, provide details: Yes No

30. Has any facility you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? If yes, please describe: Yes No

31. Does your facility do background checks on all employees and volunteers? Yes No
Describe: _____



Adult Day Care application for applicant: _____

32. Sexual molestation sublimit wanted:

\$25,000 / \$50,000

\$100,000 / \$300,000

\$50,000 / \$100,000

\$300,000 / \$300,000

Notice to applicants: In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information, or who for the purpose of misleading conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.

Applicant's Signature: _____

Printed Name: _____

Title: _____

Date: _____

Producer: _____