Northland INSURANCE

APPLICATION – ADULT DAY CARE

BUSINESS INFORMATION

1. Named Insured _____
2. Mailing Address _____
   Street City County State ZIP Code
3. Location of premises: ❑ Same as mailing address
   ❑ Other _____
4. Telephone ( ) _____ Fax ( ) _____
5. Contact person/phone #: Inspection _____
   Accounting/Records _____
6. Business type: ❑ Individual ❑ Partnership ❑ Corporation ❑ LLC
   ❑ Trust ❑ Other _____
7. Operating as: ❑ For Profit ❑ Nonprofit ❑ Other _____
8. Interest of Named Insured in premises: ❑ Owner ❑ General Lessee ❑ Tenant ❑ Other _____
9. Part occupied by Named Insured: ❑ Entire ❑ Portion(____%) ❑ Other (Lessor's Risk Only)
10. Date business established _____

DESIRED TERMS AND CONDITIONS

1. Coverage desired: ❑ General Liability ❑ Professional Liability
2. Limit of Liability 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. Contractual Liability: ❑ (Attach copy of contract) No separate limit
5. Effective Date Desired _____ Term Desired _____

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

1. Age of building _____
2. Construction _____
3. Number of floors _____
4. Total square footage _____
5. Number of exits _____

	Yes	No
6. Central station alarm	❑	❑
7. Emergency lighting	❑	❑
8. Fully sprinklered	❑	❑

If no, describe extent of sprinklering:
_____
_____

9. Last update: Wiring _____ Plumbing _____

		Yes	No
10. Smoke detectors in:	All rooms	❑	❑
	Halls	❑	❑
11. Are there any swimming pools?		❑	❑
12. Has emergency evacuation plan been prepared?		❑	❑
13. Are both scheduled and unscheduled fire and emergency drills conducted?		❑	❑
14. Are emergency facilities readily available?		❑	❑

If yes, describe. _____

_____

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. Also attach audited financial statement or annual report*.

   _____

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

	Yes	No
5. Are there procedures in place for participant screening and acceptance?	❑	❑
6. Are current records and files maintained on each participant?	❑	❑
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

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. Are any staff working 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
6. Educational background or residency program check, when applicable.	❑	❑	❑
7. Previous employers check.	❑	❑	❑
8. Personal references check.	❑	❑	❑
9. 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.	❑	❑	❑
10. Criminal background check.	❑	❑	❑

11. 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, 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?	❑	❑
4. Do you have: a. Written job descriptions	❑	❑
Policies and/or procedures manual	❑	❑
Full-time administrator or medical director on staff	❑	❑
Formalized loss control and claim prevention training program	❑	❑
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 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 nonrenewed 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					
Year	**Carrier**	**Policy Number**	**Coverage**	**Check if Claims-Made**	**Premium**
				❑	
				❑	
				❑	

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

IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE

For information about how Northfield compensates its agents, brokers and program managers, please visit this website:

http:/ / www.northlandins.com/ Producer_Compensation_Disclosure.asp

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Northfield Insurance Company, c/ o Law Department, 385 Washington St., St. Paul, MN 55102.