UNDERWRITERS DIRECT ACCESS

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ADULT DAYCARE

A. General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: _____ Fax: _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

_____

Contact Person: _____ Producer's Name: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

_____

_____

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other: _____

Is this a new business? ☐ Yes ☐ No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: _____

_____

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: _____

_____

_____

Annual Payroll: $ _____ Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: _____

_____

_____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? ☐ Yes ☐ No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: _____

Fax: _____ Years with Company: _____

Employee's Responsibilities: _____

B. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor ever had a claim? ☐ Yes ☐ No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? ☐ Yes ☐ No

If the standard markets are declining placement, please explain why: _____

_____

C. Other Insurance

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	2	3
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	$	$	$

D. Desired Insurance

Per Act/Aggregate		OR	Per Person/Per Act/Aggregate
☐	$50,000/$100,000	☐	$25,000/$50,000/$100,000
☐	$150,000/$300,000	☐	$75,000/$150,000/$300,000
☐	$250,000/$1,000,000	☐	$100,000/$250,000/$1,000,000
☐	$500,000/$1,000,000	☐	$250,000/$500,000/$1,000,000
☐	Other: _____	☐	Other: _____

Self-Insured Retention (SIR): ☐ $1,000 (Minimum) ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

E. Business Activities

1. Premises Information:
   a. ☐ Occupied as Dwelling
   b. ☐ Constructed for Day Care Operation
   c. ☐ Constructed as Dwelling and Converted to Day Care Center
   d. ☐ Constructed as Commercial Building and Converted to Day Care Center
   e. ☐ Other (please explain): _____
   f. Number of Stories _____ Construction Class _____ Age: _____
2. Safety information:
   a. Number of Fire Extinguishers on Premises _____
   b. Is the Fire Extinguisher inspected ☐ Monthly ☐ Quarterly ☐ Other _____
   c. Number of Exits _____
   d. Smoke Detectors? ☐ Yes ☐ No
   e. Building Sprinkler System? ☐ Yes ☐ No
   f. Fire Alarm? ☐ Yes ☐ No
   g. Are premises inspected by local safety and health authorities for building codes and health standards? ☐ Yes ☐ No

      If yes:

      i. Date of Last Inspection: _____
      ii. Name of entity conducting inspection: _____
      iii. Were there any violations discovered or citations issued? ☐ Yes ☐ No

         If yes,

         (1) Please describe: _____
         (2) Have violations been corrected? ☐ Yes ☐ No

            If yes, explain: _____
3. Is Applicant Licensed? ☐ Yes ☐ No

   If yes, type of license _____

   License number: _____
4. Do you require teachers to be certified? ☐ Yes ☐ No

   Identify type of Certification required: _____
5. What is maximum number of clients permitted by license? _____
6. What is maximum number of clients on premises at any one time? _____

7. When are clients on premises?
   a. _____A.M. to _____ P.M.
   b. Number of days per week: _____
8. Average daily attendance? _____
9. Indicate type of facility? ☐ Social ☐ Medical ☐ Mental
10. Indicate type of counseling provided, if any: ☐ Financial ☐ Medical
11. Is this an in-home facility? ☐Yes ☐ No
    If yes, explain: _____
12. Are clients with physical or emotional disabilities accepted? ☐Yes ☐ No
    If yes, identify types of disabilities: _____
    _____
13. Are there any non-ambulatory attendees? ☐Yes ☐ No If yes, how many? _____
14. Are there any Alzheimer afflicted adults? ☐Yes ☐ No If yes, how many? _____
15. Describe how illnesses or injuries are handled: _____
    _____
16. Is there a doctor on staff or on call? ☐Yes ☐ No If Yes, please explain: _____
    _____
17. Does Applicant have Workers' Compensation coverage in force? ☐Yes ☐ No
18. Does Applicant lease employees? ☐Yes ☐ No
19. Is there any physical therapy exposure at this facility? ☐Yes ☐ No
20. Is there any administering of medicine at this facility? ☐Yes ☐ No
    If yes, explain: _____
21. Does Applicant have accident and health policy? ☐Yes ☐ No
    If yes, what limits? _____
22. Attach pictures/diagrams, etc. of equipment and facility.
23. Describe special exercise equipment used: _____
    _____
24. Is the yard fully fenced? ☐Yes ☐ No
25. Are special classes taught? ☐Yes ☐ No
    If yes, please describe: _____
    _____
26. Is there a swimming pool on premises: ☐Yes ☐ No
    If yes,
    a. Is it enclosed? ☐Yes ☐ No
    b. Include size, depth at each end number and height of diving boards: _____

27. Are there animals on the premises: ☐Yes ☐ No

    If yes, explain: _____

28. Are off premises field trips conducted? ☐Yes ☐ No

    If yes,

    a. How often? ☐ Weekly ☐Monthly ☐ Other: _____

    b. How are clients transported? _____

    c. Do you require driver of vehicle to have chauffeur license? ☐Yes ☐ No

    d. Ave # of miles traveled: _____

    e. Describe field trips: _____

    f. Attach a list of all attendants/teachers with a description of his/her experience, educational background and certificates and/or licenses.

29. Describe procedures for the list below including process to notify guardians:

    Accidents: _____

    Illness: _____

30. Is a medical care release form signed by parent/guardian required? ☐Yes ☐ No

    If yes, attach copy of release.

31. Are staff required to be CPR and/or First Aid certified? ☐Yes ☐ No

32. Provide copy of any training manual used.

33. Please describe all the activities at this facility: _____

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer’s accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant’s facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name