apogee insurance group
a Berkshire Hathaway Company

Adult Day Care
Mainform Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone number:

4. Date established:

5. Applicant's practice is a:

☐ Solo practitioner (unincorporated)	☐ Solo practitioner (incorporated)
☐ Corporation (for-profit)	☐ Corporation (non-profit)
☐ Professional Association	
☐ Other (please describe):	

6. a. Please provide a detailed description of operations:

   b. Hours of operation:

7. Please state sources and amounts of total revenue:

		in last 12 months	for next 12 months
Charitable contributions		$	$
Government funding		$	$
Fee for services		$	$
Other – specify:		$	$

Operations and Activities

8. Is the applicant licensed or certified? Yes ☐ No ☐

9. Indicate the licensed daily capacity:

10. Indicate the actual average daily attendance:

11. State the approximate division of patients among:

Alcoholics	%	Psychiatric	%
Communicable	%	Drug addicts	%
Non-ambulatory	%	Senile/Dementia	%
Alzheimer's	%	Mentally retarded	%
Medical	%	Other (please specify):	%

12. Are any private home health services provided? Yes ☐ No ☐

    If Yes, please explain:

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13. Is there any physical therapy provided at this facility? Yes ☐ No ☐

    If Yes, please explain:

14. Is any medication administered at this facility? Yes ☐ No ☐

    If Yes, please explain:

15. Is there a physician on staff or on call? Yes ☐ No ☐

    If Yes, please explain:

16. Does the applicant operate any residential facilities? Yes ☐ No ☐

    If Yes, please attach an explanation.

17. Does the applicant administer any methadone treatment? Yes ☐ No ☐

    If Yes, please describe treatment and controls used and indicate number of treatments used:

    in the last 12 months: ______ in the next 12 months: ______

18. Does the applicant (wholly or in part) operate any hospital, nursing home, or other institution where medical services are customarily rendered? Yes ☐ No ☐

    If Yes, please give details, including name, location, size, and number of beds:

19. Does the applicant (wholly or in part) operate any other business other than as described in Question 6?

20. Does the applicant perform:

    a. acupuncture or acupuncture anesthesia? Yes ☐ No ☐
    b. angiography/arteriography/venography? Yes ☐ No ☐
    c. catheterization (other than urinary or umbilical)? Yes ☐ No ☐
    d. closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? Yes ☐ No ☐
    e. physchiatric shock therapy? Yes ☐ No ☐
    f. silicone injenctions? Yes ☐ No ☐
    g. laser treatments? Yes ☐ No ☐

h. hypnosis? Yes ☐ No ☐

i. spinal anesthesia (other than saddle blocks or caudals)? Yes ☐ No ☐

If Yes to any of the above, please provide a full description:

Staffing Information

21. a. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted
Registered Nurses		
Nurse Practitioners		
Nurses, licensed practical		
Paramedics/EMTs		
Physicians		
Physiotherapists		
Social Workers		
Counselors		
Phychologists		
Nutritionists/Dieticians		
Other – specify:		

i. Are all the above individuals licensed in accordance with all applicable state laws? Yes ☐ No ☐

If No, please explain in the comments section.

ii. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

iii. Do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

b. Has the applicant or have any of the above employees:

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

If Yes to any of the above, please explain in the comments section.

22. Provide the name of the applicant's Medical Director and attach a copy of his/her Curriculum Vitae (CV).

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Risk Management Procedures

23. Please check Yes/No if the following security/safety measures are taken:

a. Daily attendance taken Yes ☐ No ☐
b. Alarms on all outside doors Yes ☐ No ☐
c. Full supervision of all activities Yes ☐ No ☐
d. Full fencing on any outdoor/recreation areas Yes ☐ No ☐
e. Video surveillance Yes ☐ No ☐
f. Sprinkler systems Yes ☐ No ☐
g. Background checks on all staff Yes ☐ No ☐

Insurance and Claims History

24. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please explain in the comments section.

25. Does any person to be insured have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐

If Yes, please attach complete details including a description of the incident(s).

26. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐

If Yes, please complete a supplemental claims information form for each claim.

27. How many claims have been made in the last five (5) years? ☐

28. a. List prior professional liability insurers for the past five years (if none, please tick box) ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date? ☐

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29. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date? ☐

Comments Section

It is understood and agreed that with respect to questions 25 and 26, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.
A copy of this application should be retained for your records.