Facility Name: _____

1. Corp. or Applicant's Name: _____

2. Mailing Address: _____

3. Location Address: _____

4. Type: Individual: _____ Partnership: _____ Corporation: _____ Other: _____

5. Contact Person: _____ Phone Number: _____

6. Proposed Effective Date: _____ Proposed Expiration Date: _____

7. Limits Desired: General Aggregate $200,000 $300,000 $500,000
   Each Occurrence (Circle Limits) $ 50,000 $100,000 $100,000

8. Type of Facility: ALF: _____ AFCH: _____
   Group Home: _____ Other: _____

9. How many years have you been in business? _____

10. Are you Licensed by the State? Yes: _____ No: _____ License #: _____

11. Licensed capacity: _____ License expiration date: _____

12. Has your license ever been revoked, suspended or restricted? Yes: _____ No: _____

    If yes, provide details: _____

13. Number of licensed beds: _____

14. Degree of care provided, (check all that are provided or assisted with):
    Bathing: _____ Dispensing of medication: _____
    Dressing: _____ Other: _____

15. Breakdown of residents by age group:
    Under 18 years: _____ 51 to 65 years: _____
    18 to 35 years: _____ Over 65 years: _____
    36 to 50 years: _____

16. Are there any residents diagnosed by a physician as having Alzheimer's Disease?

    Yes: _____ No: _____ If so, how many? _____

17. Are there any residents diagnosed by a physician as having Dementia?

    Yes: _____ No: _____ If so, how many? _____

18. Are there any non-ambulatory clients? Yes: _____ No: _____
    If so, how many? _____

19. What is the number of Residents: _____ Staff hours per week: _____

20. Are criminal background checks obtained on all current and potential employees:
    Yes: _____ No: _____

21. Have you or any employee, volunteer or other person working for you ever been arrested, convicted or had allegations made against you? Yes: _____ No: _____
    If yes, provide details: _____

22. Any off-premises field trips/activities? Yes: _____ No: _____
    If so, provide frequency and details: _____

23. Are precautions taken to keep track of residents? Yes: _____ No: _____
    Sign out procedures? Yes: _____ No: _____
    Alarms on doors? Yes: _____ No: _____

24. Does your facility have a central station alarm? Yes: _____ No: _____

25. Does your facility have a sprinkler system? Yes: _____ No: _____

26. Number of stories: _____

27. Is there a swimming pool, jacuzzi, beach or other water exposure on the premises?
    Yes: _____ No: _____ Used by residents? Yes: _____ No: _____
    Fenced: Yes: _____ No: _____ Diving Board? Yes: _____ No: _____

28. Is there a dog on the premises? Yes: _____ No: _____

29. Prior carrier information:

Insurance Company	Policy Period		Limits	Premium

30. Has your coverage ever been cancelled or non-renewed by a previous carrier?
    Yes: _____ No: _____
    If yes, please explain: _____

31. Has there ever been a claim: Yes: _____ No: _____
    If yes, please explain: _____

32. Do you have any professionals under contract? Yes: _____ No: _____
If yes, do you obtain certificates of insurance for each other? Yes: _____ No: _____

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claims or any application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Signature of applicant*: _____

Title (Owner, Partner or Officer): _____ Date: _____

***Signing this application does not bind the applicant or the company to complete the insurance.**

Signature of Agent: _____

Agent license number: _____

You must include the following documentation:

1) **Original, signed application**
2) **Prior insurance company and policy number**
3) **Detailed information regarding any past claims**
4) **Copy of License(s)**
5) **Completed Diligent Effort**
6) **Copy of Premium Finance Contract**
7) **Copy of most recent Agency for Health Care Survey and Letter of Compliance as to any deficiency found in survey**
8) **Other:** _____

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