Texas Specialty Underwriters, Inc.
510 Turtle Cove Blvd., Suite 200
Rockwall, Texas 75087
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Adult Day Care General Liability Application

Applicant's Name ______________________

Mailing Address ______________________

____

Location ______________________

____

Web Site Address ______________________

Agent Name ______________________

Address ______________________

____

PROPOSED EFFECTIVE DATE:

From ____________ **To** ____________

12:01 A.M., Standard Time at the address of the Applicant.

Applicant is: ❑ Individual ❑ Corporation ❑ Partnership ❑ Joint Venture
❑ Limited Liability Company ❑ Other (Specify): ______________________

LIMITS OF LIABILITY REQUESTED		PREMIUMS
General Aggregate	$	Premises/Operations
Products & Completed Operations Aggregate	$	$
Personal & Advertising Injury	$	Products/Completed Operations
Each Occurrence	$	$
Fire Damage (any one fire)	$	Other
Medical Expense (any one person)	$	$
Other Coverages, Restrictions, and/or Endorsements Deductible	$	Total $

A. **Number of years in business?** ____________

B. **Is applicant licensed?** .... ❑ Yes ❑ No

Is a license required by the state? .... ❑ Yes ❑ No

C. **What is maximum number of clients permitted by license?** ______________________

D. **What is maximum number of clients on premises at any one time?** ______________________

Average daily attendance? ______________________

E. **Please describe all the activities at this facility:** ______________________

____

____

____

F. **Indicate type of facility:** ❑ Social ❑ Medical ❑ Mental

G. **Indicate type of counseling, if any, provided:** ❑ Financial ❑ Medical

H. **Is this an in-home facility?** .... ❑ Yes ❑ No

If yes, please explain: ______________________

____

I. **Is there a swimming pool on the premises?** ☐ Yes ☐ No

If yes:

1. Number of pools? ________________
2. Are the pools fenced? ☐ Yes ☐ No
3. Are the rules posted? ☐ Yes ☐ No
4. Is there life-safety equipment at poolside? ☐ Yes ☐ No
5. If there a diving board, platform, or slide? ☐ Yes ☐ No
6. Is a certified lifeguard or CPR certified attendant present at all times? ☐ Yes ☐ No

J. **Describe any special equipment on premises:** ________________

K. **Any off-premises field trips?** ☐ Yes ☐ No

If so, how many? ________ Describe: ________________

L. **Describe the building, including age, construction, number of stories, alarms, sprinklers, etc.:** ________________

M. **Are there any non-ambulatory attendees?** ☐ Yes ☐ No

If yes, how many? ________________

N. **Are there any Alzheimer's afflicted adults?** ☐ Yes ☐ No

If yes: How many? ________________

Are there anti-wandering devices on all the exits? ☐ Yes ☐ No

O. **Describe how injuries or illnesses are handled:** ________________

P. **Is there a doctor on staff or on call?** ☐ Yes ☐ No

If yes, please explain: ________________

Q. **Does applicant have Workers' Compensation coverage in force?** ☐ Yes ☐ No

R. **Ratio of caregivers to clients:** ________________

S. **Total number of employees:** ________________

T. **Is there any overnight exposure?** ☐ Yes ☐ No

If yes, please explain: ________________

U. **Is there any physical therapy exposure at this facility?** ☐ Yes ☐ No

V. **Is there any administering of medicine at this facility?** ☐ Yes ☐ No

If yes, please explain: ________________

W. **Has the applicant had any past or present allegations of physical/sexual abuse?** ☐ Yes ☐ No

If yes, explain: ________________

X. **During the past three years has any company ever cancelled, declined or refused to issue similar insurance to the applicant?** (Not applicable in Missouri.) ☐ Yes ☐ No

If yes, explain: ________________

Y. Does applicant have an accident and health policy? ☐ Yes ☐ No

If yes, what limits? ______________________

Z. Does applicant have other business ventures for which coverage is not requested? ☐ Yes ☐ No

If yes, explain and advise where insured: ______________________

____

Previous Insurer and Loss History: Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior 3 years.

YEAR	COMPANY	POLICY NO.	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF NEW YORK:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICANT'S SIGNATURE: ______________________ DATE: __________

AGENT NAME: ______________________ AGENT LICENSE NUMBER: __________

(Applicable to Florida Agents Only.)

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT __________

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE NOT APPLICABLE