Yates & Associates
Insurance Services

NORTHERN CALIFORNIA: (209) 472-7042 - (800) 472-7043
SOUTHERN CALIFORNIA: (714) 550-5050 - (800) 660-1125
SAN DIEGO: (800) 660-1125

License #0705050

Halfway House General Liability and Professional Liability Application

Applicant's Name _____
Mailing Address _____
_____
Location _____
_____

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 ☐ 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)		$	$
Professional Liability	Each Occurrence	$	Other
	Aggregate	$	$
Other Coverages, Restrictions, and/or Endorsements Sexual and/or Physical Abuse: ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000			Total
	Deductible	$	$

1. **Applicant operates as:** ☐ Profit ☐ Nonprofit Number of years in operation: _____

2. **How long under present management?** _____ (If fewer than five years, attach principals' resumes. If principals in the firm do not have a health care background, then also include the resume of the individual responsible for hiring, screening and monitoring the work activities of your employees.)

   Is facility owned by physician(s)? ☐ Yes ☐ No

3. **Type of operation:**
   - ☐ Outpatient aftercare and support program (AA, Al-Anon, etc.)
   - ☐ Outpatient counseling or guidance center
   - ☐ Crises centers (rape, domestic violence, etc.)
   - ☐ Non-medical drug and alcohol rehabilitation center
   - ☐ Homeless shelters
   - ☐ Mission or settlement house

   Describe type of operation and services provided (attach brochure and/or advertising material if available): _____

4. **Operations conducted in the following states:**
   State: _____ Licensed with state? ☐ Yes ☐ No License #: _____
   State: _____ Licensed with state? ☐ Yes ☐ No License #: _____
   State: _____ Licensed with state? ☐ Yes ☐ No License #: _____
5. **Has license ever been revoked?** ☐ Yes ☐ No If yes, explain: _____
6. **Name all subsidiary companies/locations and others coming under applicant's control** (if none, please state):
   _____
7. **Has the applicant sold, acquired or discontinued any operations in the last five years?** ☐ Yes ☐ No
   If yes, please explain: _____
8. **Is at least one of the principals or an Administrator/Director involved in the operation on a full-time basis?**
   ☐ Yes ☐ No
9. **Physical features of risk:**
   a. Construction of building: _____
   b. Number of floors: _____ On which floor(s) is applicant located? _____
      Square foot area occupied by the applicant: _____
   c. Year built: _____
   d. Equipped with sprinkler system? ☐ Yes ☐ No
      Equipped with fire alarm? ☐ Yes ☐ No ☐ Central station ☐ Local alarm
      Equipped with smoke detectors? ☐ Yes ☐ No How many on each floor? _____
   e. Number of fire extinguishers on premises: _____ Number of fire escapes: _____
   f. Is smoking allowed on premises? ☐ Yes ☐ No If yes, where is it permitted? _____
   g. Is there a swimming pool, hot tub/spa on premises? ☐ Yes ☐ No
   h. Was building originally built for this type of occupancy? ☐ Yes ☐ No
10. **Emergency procedures:**
    a. Do you have a written Emergency Evacuation Plan? ☐ Yes ☐ No
    b. Does your plan include advance agreement of transportation and temporary shelter? ☐ Yes ☐ No
    c. Are evacuation procedures posted in all parts of your facility? ☐ Yes ☐ No Bilingual? ☐ Yes ☐ No
    d. How often are drills conducted? _____
11. **State patients'/residents' ages—from:** _____ (youngest) to _____ (oldest) Average age: _____
12. **Physicians on premises, if any, are:**
    ☐ Private practitioners (personal physicians of the resident)
    ☐ Employees of the applicant
    ☐ Contracted physicians through written contract with applicant
    If contracted physician, are certificates (evidence) of professional liability insurance required and kept on file?
    ☐ Yes ☐ No
13. **Do services provided include Infusion Therapy?** ☐ Yes ☐ No
    Does treatment process involve the administration of methadone or other drugs? ☐ Yes ☐ No
14. **Are employees authorized to use their personal vehicles to transport residents or patients?** ☐ Yes ☐ No
15. **Are residents/patients placed in applicant's facility by court order?** ☐ Yes ☐ No
16. **Any involvement in medical detoxification?** ☐ Yes ☐ No
17. **Does facility accept prisoners on work release or rehabilitation programs?** ☐ Yes ☐ No

18. **Does facility provide pregnancy and/or abortion counseling services?** ☐ Yes ☐ No

19. **Does facility, if an inpatient facility, accept children under the age of 18?** ☐ Yes ☐ No
If yes, does applicant also require the child's guardian to be in residence at the same facility? ☐ Yes ☐ No

20. **Is facility a foster home or foster care facility?** ☐ Yes ☐ No

21. **Does facility provide inpatient services for either of the following:**
   a. **Developmentally Disabled**—Adults or children able to care for themselves despite their disability or mental retardation. Examples of this category include Downs Syndrome, autism, and brain injuries. This category does not include individuals whose primary diagnosis is an emotional or mental illness. ☐ Yes ☐ No
   b. **Mentally Disabled**—Adults or children able to care for themselves (with substantial numbers able to hold jobs). Behavior is controlled through medication and monitored by their personal physician. This category would include individuals whose primary diagnosis is an emotional or mental illness including but not limited to schizophrenia, psychopathic and sociopathic diagnosis. ☐ Yes ☐ No

22. **Does the applicant provide bed and board facilities?** ☐ Yes ☐ No If yes, number of beds: _____
Length of stay: from _____ (shortest) to _____ (longest) Average: _____

23. **Does the applicant provide outpatient services?** ☐ Yes ☐ No
If yes, number of annual outpatient visits: _____

24. **Explain arrangement for medical emergencies** (i.e., M.D. on call, transfer arrangements with hospital, etc.):
_____

25. **As part of hiring/screening of new employees, does applicant:**
   a. Obtain copies of their professional licenses/certifications? ☐ Yes ☐ No
   b. Contact applicants' references before they are hired? ☐ Yes ☐ No
   c. Require that they carry their own professional liability policy? ☐ Yes ☐ No

26. **Total number of employees:** _____

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

28. **Does applicant lease employees?** ☐ Yes ☐ No

29. **Does applicant have any contractual agreements wherein applicant assumes the liability of others?**
☐ Yes ☐ No
If yes, please attach a list of each entity that has requested to be named as an additional insured and the type of service(s) applicant provides.

30. **Any other premises or operations exposures not stated in this application?** ☐ Yes ☐ No
If yes, attach a complete description and underwriting/rating information.

SCHEDULE OF HAZARDS

Loc. No.	Classification	Class. Code	Premium Bases: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate		Premium	
					Prem./ Ops.	Products/ Comp. Ops.	Prem./ Ops.	Products/ Comp. Ops.

31. **During the past five years, have any claims been made or suit brought against the applicant because of alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation?**

☐ Yes ☐ No If yes, date: _____ Please explain: _____

32. **During the past three years, has any company canceled, declined, or refused similar insurance to the applicant?** (Not applicable in Missouri.) ☐ Yes ☐ No If yes, explain: _____

Previous Insurer: Indicate premium and losses for past three years. Describe all losses.

YEAR	COMPANY	POL. #	OCCURRENCE OR CLAIMS MADE	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.

NAME AND TITLE _____

APPLICANT'S SIGNATURE _____ DATE _____

AGENT NAME _____ AGENT LICENSE NUMBER _____

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