



COLONIAL GENERAL INSURANCE AGENCY, INC.

P.O. Box 14770, Scottsdale, AZ 85267-4770
8475 E. Hartford Dr., Scottsdale, AZ 85255
(480) 991-7889 WATS (800) 848-8860
Fax (480) 948-1394 Toll Free (866) 240-8807

P.O. Box 571770, Murray, UT 84157-1770
5373 S. Green St., Suite 525, Murray, UT 84123
(801) 290-1144 WATS (800) 594-8900
Fax (801) 290-1160 Toll Free (800) 332-9285

Adult Day Care General Liability Application

Applicant's Name _____
 Mailing Address _____

 Location _____

 Web Site Address _____

Agency Name _____
 Agent _____
 Address _____

 E-Mail _____
 Phone _____

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		Total
Deductible	\$	

- 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. Is 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:** _____
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- 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, please 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, please 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, please 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 three years. Loss run attached

YEAR	COMPANY	POL. 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.

NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____

AGENT NAME: _____ AGENT LICENSE NUMBER: _____

(Applicable to Florida Agents Only.)

IOWA LICENSED AGENT: _____

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"

Agent's E-mail Address _____ Preferred Method of Correspondence? E-Mail Fax Regular Mail

Applicant's E-mail Address _____ Preferred Method of Correspondence? E-Mail Fax Regular Mail