



Max Specialty

ADULT DAY CARE APPLICATION

AGENCY INFORMATION

1. **APPLICANT INFORMATION**

EFFECTIVE DATE: _____

NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE: _____ WEBSITE: _____

TERM: _____ YEARS IN BUSINESS: _____ NEW VENTURE: YES NO

2. INDIVIDUAL CORPORATION PARTNERSHIP OTHER (EXPLAIN) _____

A. GENERAL LIABILITY

\$100,000/\$300,000 \$300,000/\$600,000 \$500,000/\$1,000,000 \$1,000,000/\$2,000,000 OTHER: _____

B. PROPERTY

1. IS PROPERTY PROHIBITED IN OUR COASTAL GUIDELINES? YES NO

2. CAUSE OF LOSS BASIC BROAD SPECIAL

3. CONSTRUCTION _____ PROTECTION CLASS _____ SQUARE FEET _____ BUILDING AGE _____

4.

COVERAGE DESIRED	LIMIT	RC/ACV	CO-INS / INDEMNITY	DEDUCTIBLE
BULDING				
BUSINESS PROPERTY				
BUSINESS INCOME				

5. LOSS PAYEE: _____

6. MORTGAGEE: _____

C. FACILITY

1. IS THE APPLICANT A LICENSED COMERCIAL ADULT DAY CARE PROVIDER? YES NO

2. STATE LICENSE NUMBER: _____ YEARS AT THIS LOCATION: _____

3. MAXIMUM NUMBER OF CLIENTS PERMITTED BY LICENSE? _____ ON SITE AT ANY GIVEN TIME _____

4. CLIENT TO SUPERVISOR RATIO? _____ 4a. # FULL TIME STAFF? _____ # PARTTImESTAFF _____

5. DAYS AND HOURS OFOPERATION? _____

6. # OF ROOMS IN FACILITY _____ 6a. # OF EXITS ON EACH FLOOR? _____

7. INDICATE TYPE OF FACILITY SOCIAL MEDICAL MENTAL

8. INDICATE TYPE OF HOUSING, IF ANY PROVIDED SOCIAL MEDICAL MENTAL

9. IS THIS AN IN-HOME FACILITY YES NO IF YES, EXPLAIN: _____

10. IS THERE A SWIMMING POOL ON THE PREMISES? YES NO IF YES, IS IT FENCED? YES NO

11. DESCRIBE ANY SPECIAL EQUIPMENT ON THEPREMISES: _____

D. FIRE PROTECTION

1. WHAT TYPE OF COOKING EQUIPMENT? _____
2. IS THERE A FIRE SUPPRESSION SYSTEM OVER ALL COOKING EQUIPMENT? YES NO
3. HOW OFTEN IS IT SERVICED? MONTHLY SEMI-ANNUALLY ANNUALLY OTHER _____
4. ARE THERE SMOKE DETECTORS IN EACH ROOM AND IN COMMON AREAS? YES NO

E. TRIPS

1. DOES THE APPLICANT SPONSOR OFF PREMISES TRIPS? YES NO
2. IF SO, HOW MANY PER YEAR? _____
3. WHAT TYPES OF TRIPS AND WHERE DO THEY GO? _____
4. DESCRIBE ALL OTHER ACTIVITIES AT THIS FACILITY. _____

F. CLIENTELE

1. ARE THERE ANY NON-AMBULATORY ATTENDEES? YES NO IF YES, HOW MANY? _____
2. ARE THERE ANY ALZHEIMER'S AFFLICTED ADULTS? YES NO IF YES, HOW MANY? _____
3. ARE THERE ANY PROTECTIVE MEASURES IN PLACE TO PREVENT ALZHEIMER'S AFFLICTED ADULTS FROM WANDERING? YES NO
IF YES, DESCRIBE: _____
4. IS THERE A MEDICAL PROVIDER ON STAFF? YES NO 4a. IS THERE OVERNIGHT EXPOSURE YES NO
5. IS THERE ANY ADMINISTRATION OF MEDICATION? YES NO
6. IF PHYSICAL THERAPY, IS THERE A LICENSED PRACTITIONER ON STAFF? YES NO
7. DESCRIBE HOW INJURY AND/OR ILLNESS IS HANDLED _____

G. LOSS HISTORY (3 YEARS)

YEAR	CARRIER	LIMITS	PREMIUM	DATE OF LOSS	DESCRIPTION OF LOSS	AMOUNT INCURRED

APPLICANT SIGNATURE: _____ DATE: _____

PRODUCER NAME: _____

ADDRESS: _____