

# SCOTTSDALE

SURPLUS LINES INSURANCE COMPANY

8877 North Gainey Center Drive • Scottsdale, Arizona 85258

1-800-423-7675 • Fax (480) 483-6752

www.scottsdaleins.com

## Halfway House 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)	\$		
Errors and Omissions	Each Claim	\$	Other
	Aggregate	\$	
Other Coverages, Restrictions, and/or Endorsements			Total
Sexual and/or Physical Abuse:			
<input type="checkbox"/> \$25,000/\$50,000 <input type="checkbox"/> \$50,000/\$100,000 <input type="checkbox"/> \$100,000/\$300,000			
	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:**

- |   |  |
|---|--|
| <input type="checkbox"/> Outpatient aftercare and support program (AA, Al-Anon, etc.) | <input type="checkbox"/> Blood testing clinic                        |
| <input type="checkbox"/> Outpatient counseling or guidance center                     | <input type="checkbox"/> Healthcare clinic                           |
| <input type="checkbox"/> Crises centers (rape, domestic violence, etc.)               | <input type="checkbox"/> Psychiatric institution                     |
| <input type="checkbox"/> Non-medical drug and alcohol rehabilitation center           | <input type="checkbox"/> Youth hostel                                |
| <input type="checkbox"/> Homeless shelters  | <input type="checkbox"/> Hospice facility                            |
| <input type="checkbox"/> Mission or settlement house                                  | <input type="checkbox"/> Birth control, pregnancy or abortion clinic |

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

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**4. Operations conducted in the following states:**

State: \_\_\_\_\_ Licensed with state? ☐ Yes ☐ No License No.: \_\_\_\_\_

State: \_\_\_\_\_ Licensed with state? ☐ Yes ☐ No License No.: \_\_\_\_\_

State: \_\_\_\_\_ Licensed with state? ☐ Yes ☐ No License No.: \_\_\_\_\_

**5. Has license ever been revoked?** ..... ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

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**6. Name all subsidiary companies/locations and others coming under applicant's control (if none, please state):**

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**7. Has the applicant sold, acquired or discontinued any operations in the last five years?** ..... ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

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**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 or 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**

Dialysis? .....☐ Yes ☐ No

Physical 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? .....☐ Yes ☐ No**

**18. Does facility accept teens with a past history of violence or attempted suicide? .....☐ Yes ☐ No**

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

**20. Does facility, if an inpatient facility, accept children under the age of eighteen (18)? .....☐ Yes ☐ No**

If yes, does applicant also require the child's guardian to be in residence at the same facility?.....☐ Yes ☐ No

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

**22. 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

**23. Does the applicant provide bed and board facilities? .....☐ Yes ☐ No**

If yes, number of beds: \_\_\_\_\_

Length of stay: from \_\_\_\_\_ (shortest) to \_\_\_\_\_ (longest) Average: \_\_\_\_\_

24. Does the applicant provide outpatient services? ..... ☐ Yes ☐ No

If yes, number of annual outpatient visits: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

26. 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

27. Total number of employees: \_\_\_\_\_

28. Does applicant have Workers' Compensation coverage in force? ..... ☐ 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 suits 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: \_\_\_\_\_

If yes, 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, please explain: \_\_\_\_\_

\_\_\_\_\_

**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.** ☐ See loss run attached

Year	Company	Pol. No.	Occurrence or Claims Made	Premium	Losses Paid	Losses Reserved	Description

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

If yes, explain and advised where insured: \_\_\_\_\_  
 \_\_\_\_\_

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"**