



# United States Liability Insurance Group

## Non-Profit Group Homes for the Mentally Retarded/Developmentally Disabled

### APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

**Facility License must be attached to this application.**

**GENERAL INFORMATION**

1. Applicant \_\_\_\_\_
2. Mailing Address. \_\_\_\_\_
3. Location of Risk (including Zip Code): If located in Alaska, Florida, Hawaii or Louisiana - Prohibited \_\_\_\_\_  
 1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_  
 4) \_\_\_\_\_  
 5) \_\_\_\_\_
4. Applicant is:       Individual               Partnership               Corporation               Other \_\_\_\_\_
5. Facility is:         Profit                       Non-Profit
6. Applicant's interest in premises is:       Owner                       General Lessee       Tenant
7. Licensed By State of \_\_\_\_\_ License No. \_\_\_\_\_ (attach copy)  
 No. of Licensed Beds/Residents \_\_\_\_\_ Expiration Date \_\_\_\_\_
8. Does applicant own or operate any other types of facilities?       Yes       No      If Yes, explain \_\_\_\_\_  
 \_\_\_\_\_
9. Has license ever been suspended, revoked or placed under probation?       Yes       No      If Yes, explain \_\_\_\_\_  
 \_\_\_\_\_
10. How long has home been in operation? \_\_\_\_\_ How long under present management? \_\_\_\_\_
11. Describe affiliation, if any, (Hospital, Church, Retirement Facility, etc.) \_\_\_\_\_  
 \_\_\_\_\_
12. Contact for Audit and Inspection      Name: \_\_\_\_\_  
 Phone \_\_\_\_\_

**RESIDENT INFORMATION**

13. Identify whether the residents have any of the following:
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> Yes

  - Mild or Moderate Mental Retardation . . . . .
  - Severe or Profound Mental Retardation . . . . .
  - Mentally Disturbed/ Mentally Ill. . . . .
  - Schizophrenia/ Bipolar Disorder/ Psychosis . . . . .
  - Alzheimer's/Dementia . . . . .
  - Cerebral Palsy. . . . .
  - Non ambulatory or requiring wheelchair. . . . .
  - Violent or Aggressive Behavior / Requiring Restraint . . . . .
14. Number of residents:    Under Age 18 \_\_\_\_\_    Age 18-60 \_\_\_\_\_    Over Age 60 \_\_\_\_\_
15. Do all residents leave the facility to attend work or a sheltered workshop?       Yes       No \_\_\_\_\_  
 If no, please explain \_\_\_\_\_
16. Is there staff on premises 24 hours a day?       Yes       No  
 Is there "awake" staff at night?                       Yes       No
17. List any medications that the staff is required to administer \_\_\_\_\_
18. Are field trips regularly taken?       Yes       No      If yes, describe destinations/ frequency \_\_\_\_\_  
 \_\_\_\_\_

**19. STAFFING INFORMATION**

- Are there any formal written procedures in place for staff hiring?  Yes  No
- Is prior employment and personal references verified prior to hiring?  Yes  No
- Are criminal background checks performed prior to hiring?  Yes  No
- If No, please explain why: \_\_\_\_\_
- Are licenses and other credentials verified prior to hiring?  Yes  No
- Is there formal staff training?  Yes  No
- Does your staff employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses?  Yes  No
- Do you have a written procedure for dealing with sexual abuse?  Yes  No
- If yes, please attach a copy.
- Do you have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises?  Yes  No
- Are nurses, (RN, LPN) employed or contracted to provide care to any residents?  Yes  No

**20. PREMISES INFORMATION**

- Are smoke detectors in every unit?  Yes  No
- Are smoke detectors hard wired?  Yes  No
- Are all bathtubs and showers equipped with non-slip surfaces?  Yes  No
- Are all taps, showers, baths and hot water faucets for residents use equipped with temperature controls not to exceed 110°?  Yes  No
- Is smoking permitted in residents' rooms?  Yes  No
- If Yes, describe how smoking is controlled: \_\_\_\_\_
- Is there a swimming pool on premises?  Yes  No
- If Yes, explain use and safety measures: \_\_\_\_\_
- Are procedures in place for emergency evacuation of the premises?  Yes  No

**21. AUTO INFORMATION**

- Do your employees/volunteers use their own vehicles on agency business?  Yes  No
- If Yes, do your employees/volunteers use their personal vehicles to transport clients?  Yes  No
- If yes, do you require your employees/volunteers to carry and show evidence of personal automobile insurance?  Yes  No
- If yes, what are the minimum limits of liability required? \$ \_\_\_\_\_

**22. COMMERCIAL LIABILITY**

- Limits of Liability Requested:
- 300/300  300/600  500/500  500/1Mil  500/2Mil  500/3Mil  1Mil/1Mil  1Mil/2Mil  1Mil/3Mil
- Commercial Liability Limits Include:
- General Liability, Personal and Advertising Injury, Damage to Rented Premises and Medical Expense
  - Professional Liability - Occurrence Limit equal to the CGL Occurrence Limit
  - Patient/Resident Sexual Abuse - Occurrence Limit equal to the CGL Occurrence Limit
  - Non-Owned Auto - Occurrence Limit equal to the CGL Occurrence Limit
  - Damage to Residents'/Patients' Property - \$500 Each Occurrence/\$10,000 Aggregate
  - Evacuation Expense - \$500 Per Emergency/\$1,000 Aggregate
  - Medical Directors and Volunteers as Additional Insureds
  - \$500 Deductible per claim BI/PD

**23. COMMERCIAL PROPERTY**

Is the property eligible according to United States Liability Insurance Group Coastal Guidelines?  Yes  No

Building Information	Loc. 1	Loc. 2	Loc. 3	Loc. 4	Loc. 5
Construction					
Protection Class					
Number of Stories					
Building Area					
Year Built					
<b>Indicate Limits at 80% Coin.</b>					
Building Limit					
Personal Property Limit					
Business Income Limit					

Select: \_\_\_\_\_ Replacement cost  Basic Cause of Loss (\$500 deductible applies)

          \_\_\_\_\_ Actual Cash Value  Special Cause of Loss (\$1,000 deductible applies)

**24. PRIOR CARRIER & LOSS INFORMATION**

**Yes**      **No**

Have there been any General Liability or Professional claims in the past 3 years? .....      

If Yes, provide details \_\_\_\_\_

Have there been any Property claims in the past 3 years? .....      

If Yes, provide details \_\_\_\_\_

Have there been any allegations of Abuse or Molestation? .....      

If Yes, provide details \_\_\_\_\_

Prior Insurance Carrier \_\_\_\_\_ Expiring Premium \_\_\_\_\_

**FRAUD STATEMENT:** 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 FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

**Applicant's Warranty Statement**

The applicant warrants that the Group Home(s) submitted here for consideration of insurance coverage are maintained to provide services to adult residents diagnosed with mild to moderate mental retardation or developmental disability only, The residents are ambulatory, under the age of 60, able to provide for their own personal hygiene, can communicate sufficiently to make known their own wants and needs, and are able to differentiate between societal mores of right and wrong. The applicant further warrants that no residents have a recent history of violence or anti-social behavior (not treatable by medication) or who are mentally ill (bipolar, schizophrenic, psychotic, etc.).

The above applicant also warrants that the above statements and particulars, together with any attached or appended documents, are true and complete and do not misrepresent, misstate or omit any material facts.

Notwithstanding any of the foregoing, the applicant understands that we are not obligated or under any duty to issue a policy of insurance based upon the information.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Broker's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Some states require that we have the Name and Address of your (insured's) authorized Agent or Broker.

Name of Authorized Agent or Broker \_\_\_\_\_

Address: \_\_\_\_\_

Mail Completed Application  
Through Local Agent or Broker To: