MUSIC Adult Day Care Application

NEW ENGLAND EXCESS EXCHANGE
P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641
800-548-4301 • www.neee.com

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. FACILTIY

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

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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 APPLCANT 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

I have reviewed this application for accuracy before signing it. As a condition precedent to coverage, I hereby state that the information contained herein is true, accurate and complete and that no material facts have been omitted, misrepresented or misstated. I understand that this is an application for insurance only and that the completion and submission of this application does not bind coverage with any insurance company.

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APPLICANT SIGNATURE: _____ **DATE:** _____

PRODUCER NAME: _____

ADDRESS: _____