HISCOX PRO™

Adult Day Care
Mainform Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone number:

4. Date established:

5. Applicant's practice is a:

☐ Solo practitioner (unincorporated)	☐ Solo practitioner (incorporated)
☐ Corporation (for-profit)	☐ Corporation (non-profit)
☐ Professional Association	
☐ Other (please describe):	

6. a. Please provide a detailed description of operations:

   b. Hours of operation:

7. Please state sources and amounts of total revenue:

	in last 12 months	for next 12 months
Charitable contributions	$	$
Government funding	$	$
Fee for services	$	$
Other – specify:	$	$

Operations and Activities

8. Is the applicant licensed or certified? Yes ☐ No ☐

9. Indicate the licensed daily capacity:

10. Indicate the actual average daily attendance:

11. State the approximate division of patients among:

Alcoholics	%	Psychiatric	%
Communicable	%	Drug addicts	%
Non-ambulatory	%	Senile/Dementia	%
Alzheimer's	%	Mentally retarded	%
Medical	%	Other (please specify):	%

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12. Are any private home health services provided? Yes ☐ No ☐

If Yes, please explain:

13. Is there any physical therapy provided at this facility? Yes ☐ No ☐

If Yes, please explain:

14. Is any medication administered at this facility? Yes ☐ No ☐

If Yes, please explain:

15. Is there a physician on staff or on call? Yes ☐ No ☐

If Yes, please explain:

16. Does the applicant operate any residential facilities? Yes ☐ No ☐

If Yes, please attach an explanation.

17. Does the applicant administer any methadone treatment? Yes ☐ No ☐

If Yes, please describe treatment and controls used and indicate number of treatments used:

in the last 12 months: | in the next 12 months:

18. Does the applicant (wholly or in part) operate any hospital, nursing home, or other institution where medical services are customarily rendered? Yes ☐ No ☐

If Yes, please give details, including name, location, size, and number of beds:

19. Does the applicant (wholly or in part) operate any other business other than as described in Question 6?

20. Does the applicant perform any patient or client transportation services? Yes ☐ No ☐

If Yes, please indicate the percentage of revenue derived from transportation %

21. Does the applicant perform:

a. acupuncture or acupuncture anesthesia? Yes ☐ No ☐

b. angiography/arteriography/venography? Yes ☐ No ☐

c. catheterization (other than urinary or umbilical)? Yes ☐ No ☐

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d. closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? Yes ☐ No ☐

e. psychiatric shock therapy? Yes ☐ No ☐

f. silicone injections? Yes ☐ No ☐

g. laser treatments? Yes ☐ No ☐

h. hypnosis? Yes ☐ No ☐

i. spinal anesthesia (other than saddle blocks or caudals)? Yes ☐ No ☐

If Yes to any of the above, please provide a full description:

Staffing Information

22. a. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted
Registered Nurses		
Nurse Practitioners		
Nurses, licensed practical		
Paramedics/EMTs		
Physicians		
Physiotherapists		
Social Workers		
Counselors		
Psychologists		
Nutritionists/Dieticians		
Other – specify:		

i. Are all the above individuals licensed in accordance with all applicable state laws? Yes ☐ No ☐
If No, please explain in the comments section.

ii. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

iii. Do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

b. Has the applicant or have any of the above employees:

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

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If Yes to any of the above, please explain in the comments section.

23. Provide the name of the applicant's Medical Director and attach a copy of his/her Curriculum Vitae (CV).

Risk Management Procedures

24. Please check Yes/No if the following security/safety measures are taken:

a.	Daily attendance taken	Yes ☐ No ☐
b.	Alarms on all outside doors	Yes ☐ No ☐
c.	Full supervision of all activities	Yes ☐ No ☐
d.	Full fencing on any outdoor/recreation areas	Yes ☐ No ☐
e.	Video surveillance	Yes ☐ No ☐
f.	Sprinkler systems	Yes ☐ No ☐
g.	Background checks on all staff	Yes ☐ No ☐

Insurance and Claims History

25. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please explain in the comments section.

26. Does any person to be insured have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐

If Yes, please attach complete details including a description of the incident(s).

27. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐

If Yes, please complete a supplemental claims information form for each claim.

28. How many claims have been made in the last five (5) years?

29. a. List prior professional liability insurers for the past five years (if none, please tick box) ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

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30. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

Comments Section

It is understood and agreed that with respect to questions 25 and 26, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage

APPLICATION DISCLOSURES:

If there is any material change in the answers to the questions in this Application before the proposed policy inception date, you must notify us in writing. In such case, we have the right to cancel, withdraw, or modify any outstanding quote for insurance coverage or any policy that may have been issued.

Your submission of this Application does not obligate us to issue, or require you to purchase, a policy. You authorize us to make any inquiry in connection with this Application.

All written statements and materials provided to us in conjunction with this Application are incorporated into this Application and made a part of it.

The undersigned, as your authorized representative or agent, declares to the best of their knowledge and belief and after reasonable inquiry, that the statements made in this Application are true, accurate, and complete. The undersigned agrees that we will rely on this Application in issuing any insurance policy providing the requested coverage, and that this Application will form the basis of any such insurance policy.

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NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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.

Applicant Information:

Applicant Name:	
By (Authorized Signature):	
Name/Title:	
Date:	

Producer Information:

Producer Name:	
* Producer Signature:	
Date:	

Address of Producer:	Street:		
	City:	State:	Zip:
	E-Mail Address:		
** Producer License Number:			