



# COLONIAL GENERAL INSURANCE AGENCY, INC.

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P.O. Box 571770, Murray, UT 84157-1770  
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## 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): \_\_\_\_\_

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"

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

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 or permanent housing 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:			Rate		Premium	
			(s) Gross Sales (a) Area (t) Other	(p) Payroll (c) Total Cost	Terr.	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	Policy 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 advise 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.

**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.

**FRAUD WARNING (APPLICABLE IN FLORIDA):**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**FRAUD WARNING (APPLICABLE IN MAINE):**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**FRAUD WARNING (APPLICABLE IN TENNESSEE AND WASHINGTON):**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**FRAUD WARNING 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.

APPLICANT'S NAME AND TITLE: \_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Must be signed by an active owner, partner or executive officer)

PRODUCER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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.

Agent's E-mail Address \_\_\_\_\_ Preferred Method of Correspondence? E-Mail Fax Regular Mail

Applicant's E-mail Address \_\_\_\_\_ Preferred Method of Correspondence? E-Mail Fax Regular Mail