

Application for Liability Insurance Quotes

Please note: filling out this application will generate premium **indications** from various insurers. If, in the end, you choose one of these quotes we will need to complete that insurer's full application!

I. Applicant Information

Business or Corporate Name	Entity Type (Corporations, LLC, Sole Prop. , Etc)			
Street Address	County			
City	State	Zip	Daytime Phone	Fax
Federal Tax ID	Contact Name	E-Mail		

II. Operations

→ Type of Entity (for example, small assisted living, group home, alcohol rehab facility, etc.): _____

→ Experience in the industry of current ownership: _____

Is applicant the sole owner of this facility: _____

→ Do you perform criminal background checks on all employees? Yes No

→ Years in business under this name: _____ **Please feel free to attach any marketing material or brochures, which describe your operations.*

→ Gross Receipts for the last 12 months: \$ _____

→ Est. Gross Receipts for the next 12 months: \$ _____

→ Do you provide any of the following services?

Adult Day Care Child Day Care

Home Health Care

Other

Number of Beds by Type:	Licensed	Occupied	Number of Residents by Class:	Occupied
Independent Living	_____	_____	Geriatric	_____
Assisted Living	_____	_____	Non-Geriatric (19 – 54)	_____
Intermediate Care	_____	_____	Adolescent (12 – 18)	_____
Alzheimer's Care	_____	_____	Pediatric (0 – 11)	_____
Skilled Nursing	_____	_____	Apartments Occupied	_____
Other: _____	_____	_____	Total Number of Residents	_____

III. General Underwriting Information

→ Desired effective date: _____

→ Are you currently insured for General & Professional Liability? YES NO

If YES, please complete the following five items:

a) Name of Insurance Company: _____

b) Claims-Made Form Occurrence Form

c) If Claims-Made Form – Retroactive Date: _____

d) Limits of Insurance: _____

e) Premium: \$ _____

→ Have any claims/suits been made within the last 5 years against the applicant? *YES NO
**If YES, please attach information specifying date, description, amount paid, and amount reserved for each claim.*

→ Is the applicant aware of any circumstances, which may result in any claim or suit being made, including requests for medical records? *YES NO
**If YES, please attach information specifying date, description, amount paid, and amount reserved for each claim.*

→ Has any insurance company declined, cancelled, or refused to renew any of the applicant's insurance? *YES NO
**If YES, please attach information describing why coverage was denied or cancelled.*

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Note: This information can be found on the declarations page of your current policy. Save time by attaching a copy of your declarations page to this application and leave this section blank!

IV. Desired Coverage Information

Professional Liability: YES NO

Workers Compensation: YES NO

General Liability: YES NO

Crime Bond: YES NO

Non-Owned Auto: YES NO

Building/Contents: YES NO

Do you have a fall assessment protocol? YES NO

Is video surveillance used? YES NO

Please state the name of the administrator _____, his/her years licensed _____ and his/her tenure at this facility _____

Check the professional categories below that are applicable to your operation and provide head count and billed hours for each:

Profession	Full Time Equivalent (based on a 40 hr work week)	
	Employed (W-2)	Contracted (W-1099)
Administrative / Clerical		
Home Health Aide		
LPN / LVN		
Nurse Aide		
CNA		
Registered Nurse		
Occupational / Speech Therapist		
Social Worker		
Physical Therapist		
Respiratory Therapist		
Rehab Therapist		

Note: M.D.'s, D.D.'s, D.D.S.'s, Paramedics, PA.'s, EMT's, Nurse Midwives, and Nurse Anesthesiologists are not eligible for coverage.

→ List states of operation: _____

→ Are there any Medical Doctors on the premises? Yes No

If YES – are they operating in an administrative capacity? Yes No

If NO –please describe their duties:

Applicant's Affidavit and Signature: I hereby represent and warrant that the aforementioned statements and answers are correct and complete. I further understand that my answers and statements will be the basis for determining my insurability and premium for the applied professional liability coverage. I further understand that that the completion and signing of this application does not bind the applicant or the company to complete this insurance and supplemental information may be requested to produce a bind-able quote.

→ Signature _____

Date _____

Please return your completed application via fax or mail for a premium indication to:

Jason Miller
The Solutions Group
2101 Lockhill-Selma Rd., Suite 210
San Antonio, TX 78213
Ph: 800-866-2682
Fax: 866-811-4132
Alternate Fax: 210-568-4904
E-Mail: jamiller@swbell.net

Supplemental Information – Please Attach the Following Items:

1. If you have less than 3 years in business, the resume of the owner
2. Your latest state survey (if applicable)
3. A copy of your state license (if applicable)