

# Benchmark

**MANAGEMENT GROUP, INC.**

1730 Park Street, Suite 214 Naperville, IL 60563

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## Halfway House General Liability and Professional Liability Application

Applicant's Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 \_\_\_\_\_  
 Location \_\_\_\_\_  
 \_\_\_\_\_

Agent Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_

**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): \_\_\_\_\_

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)	\$	\$
Professional Liability        Each Occurrence	\$	Other
Aggregate	\$	\$
Other Coverages, Restrictions, and/or Endorsements 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		Total
Deductible	\$	\$

- Applicant operates as:**     Profit     Nonprofit    Number of years in operation: \_\_\_\_\_
- 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
- Type of operation:**  
 Outpatient aftercare and support program (AA, Al-Anon, etc.)  
 Outpatient counseling or guidance center  
 Crises centers (rape, domestic violence, etc.)  
 Non-medical drug and alcohol rehabilitation center  
 Homeless shelters  
 Mission or settlement house  
 Describe type of operation and services provided (attach brochure and/or advertising material if available): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**4. Operations conducted in the following states:**

State: \_\_\_\_\_ Licensed with state?  Yes  No License #: \_\_\_\_\_

State: \_\_\_\_\_ Licensed with state?  Yes  No License #: \_\_\_\_\_

State: \_\_\_\_\_ Licensed with state?  Yes  No License #: \_\_\_\_\_

5. **Has license ever been revoked?**  Yes  No If yes, explain: \_\_\_\_\_

6. **Name all subsidiary companies/locations and others coming under applicant's control** (if none, please state):  
\_\_\_\_\_

7. **Has the applicant sold, acquired or discontinued any operations in the last five years?**  Yes  No

If yes, please explain: \_\_\_\_\_

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, 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

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 on work release or rehabilitation programs?**  Yes  No

18. Does facility provide pregnancy and/or abortion counseling services?  Yes  No
19. Does facility, if an inpatient facility, accept children under the age of 18?  Yes  No  
If yes, does applicant also require the child's guardian to be in residence at the same facility?  Yes  No
20. Is facility a foster home or foster care facility?  Yes  No
21. Does facility provide inpatient services 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
22. Does the applicant provide bed and board facilities?  Yes  No If yes, number of beds: \_\_\_\_\_  
Length of stay: from \_\_\_\_\_ (shortest) to \_\_\_\_\_ (longest) Average: \_\_\_\_\_
23. Does the applicant provide outpatient services?  Yes  No  
If yes, number of annual outpatient visits: \_\_\_\_\_
24. Explain arrangement for medical emergencies (i.e., M.D. on call, transfer arrangements with hospital, etc.):  
\_\_\_\_\_  
\_\_\_\_\_
25. 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
26. Total number of employees: \_\_\_\_\_
27. Does applicant have Workers' Compensation coverage in force?  Yes  No
28. Does applicant lease employees?  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: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate		Premium	
					Prem./Ops.	Products/Comp. Ops.	Prem./Ops.	Products/Comp. Ops.

31. During the past five years, have any claims been made or suit 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: \_\_\_\_\_ 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, explain: \_\_\_\_\_

**Previous Insurer: Indicate premium and losses for past three years. Describe all losses.**

YEAR	COMPANY	POL. #	OCCURRENCE OR CLAIMS MADE	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

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.

**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.

**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.

NAME AND TITLE \_\_\_\_\_

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

AGENT NAME \_\_\_\_\_ AGENT LICENSE NUMBER \_\_\_\_\_

***(Applicable to Florida Agents Only.)***

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.

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