☒ **Scottsdale Insurance Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

☐ **Scottsdale Indemnity Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

☐ **Scottsdale Surplus Lines Insurance Company**
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

1-800-423-7675 • Fax (480) 483-6752
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Halfway House General Liability Application

Applicant's Name: _____

_____

Mailing Address: _____

_____

Location Address: _____

_____

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**

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

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture
☐ Limited Liability Company ☐ Other (Specify): _____

Limits Of Liability and Deductible Requested:

General Aggregate (other than Products/Completed Operations)	$
Products & Completed Operations Aggregate	$
Personal & Advertising Injury (any one person or organization)	$
Each Occurrence	$
Damage To Premises Rented To You (any one premise)	$
Medical Expense (any one person)	$
Errors and Omissions Coverage — Each Claim (Limits must be equal to General Liability limits) — Aggregate	$ $
Sexual and/or Physical Abuse Coverage	☐ $ 25,000/$ 50,000 (included) ☐ $ 50,000/$100,000 ☐ $100,000/$300,000
Other Coverages, Restrictions, and/or Endorsements:	$
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 employees.)

3. **Is facility owned by physician(s)?** ☐ Yes ☐ No
   If yes, is physician(s) involved in day-to-day operations? ☐ Yes ☐ No

4. **Type of operation:**
   - ☐ Birth control, pregnancy or abortion counseling/clinic
   - ☐ Blood testing or communicable disease clinic
   - ☐ Crises center (rape, domestic violence, etc.)
   - ☐ Halfway house
   - ☐ Healthcare clinic
   - ☐ Homeless shelter
   - ☐ Hospice facility
   - ☐ Medical urgent care facility
   - ☐ Mission or settlement house
   - ☐ Non-medical drug and alcohol rehabilitation center
   - ☐ Outpatient aftercare and support program (AA, Al-Anon, etc.)
   - ☐ Outpatient counseling or guidance center
   - ☐ Prisoners work-release or rehabilitation program
   - ☐ Psychiatric institution
   - ☐ Youth hostel

   Describe type of operation and services provided (attach brochure and/or advertising material if available):

   _____

   _____

5. **Does applicant provide any off-premises health care services?** ☐ Yes ☐ No
   If yes, advise: _____

6. **Total number of employees:** _____

7. **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

8. **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.: _____

9. **Has license ever been revoked?** ☐ Yes ☐ No
   If yes, explain: _____

   _____

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

    _____

11. **Has applicant sold, acquired or discontinued any operations in the last five years?** ☐ Yes ☐ No
    If yes, explain: _____

    _____

12. **Is at least one of the principals or an Administrator/Director involved in the operation on a full-time basis?** ☐ Yes ☐ No

13. Physical features of risk:

a. Year built: _____

b. Construction of building: _____

c. Number of floors: _____ On which floor(s) is applicant located? _____

Square foot area occupied by applicant: _____

d. Equipped with sprinkler system? ☐ Yes ☐ No

Equipped with fire alarm? ☐ Yes ☐ No

If yes: ☐ Central station ☐ Local alarm

Equipped with smoke detectors? ☐ Yes ☐ No

If yes, 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

If yes:

- Number of pools? _____
- Are the pools fully fenced with self-latching gates? ☐ Yes ☐ No
- Are the rules posted? ☐ Yes ☐ No
- Is there life-safety equipment at poolside? ☐ Yes ☐ No
- Is there a diving board, platform, or slide? ☐ Yes ☐ No

  If yes, height of each: _____
- Are all swimming pools, wading pools, hot tubs and spas in compliance with the federal Virginia Graeme Baker Pool and Spa Safety Act? ☐ Yes ☐ No

h. Was building originally built for this type of occupancy? ☐ Yes ☐ No

14. Evacuation procedures:

a. Does applicant have a written Emergency Evacuation Plan? ☐ Yes ☐ No

b. Does evacuation plan include advance agreement for transportation and temporary shelter? ☐ Yes ☐ No

c. Are evacuation procedures posted in all parts of the facility? ☐ Yes ☐ No

If yes, are posted evacuation procedures bilingual? ☐ Yes ☐ No

d. How often are drills conducted? _____

15. State patients'/residents' ages: Youngest _____ Oldest _____ Average age _____

16. Physicians on premises, if any, are:

☐ Private practitioners (personal physicians of the residents)

☐ Employees of 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

17. 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

18. Are employees authorized to use their personal vehicles to transport residents or patients? ☐ Yes ☐ No

19. **Are residents/patients placed in applicant's facility by court order?** ☐ Yes ☐ No

20. **Any involvement in medical detoxification?** ☐ Yes ☐ No

21. **Does facility accept prisoners?** ☐ Yes ☐ No

22. **Does facility accept teens with a past history of violence or attempted suicide?** ☐ Yes ☐ No

23. **Does facility provide pregnancy and/or abortion counseling services?** ☐ Yes ☐ No

24. **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

25. **Is facility a foster home or foster care facility?** ☐ Yes ☐ No

26. **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

27. **Does applicant provide bed and board facilities?** ☐ Yes ☐ No

    If yes, number of beds: _____

    Length of stay: From (shortest) _____ To (longest) _____ Average _____

28. **Does applicant provide outpatient services?** ☐ Yes ☐ No

    If yes, number of annual outpatient visits: _____

29. **Explain arrangement for medical emergencies** (i.e., M.D. on call, transfer arrangements with hospital, etc.):

    _____

    _____

30. **Does applicant have Workers' Compensation coverage in force?** ☐ Yes ☐ No

31. **Does applicant have any contractual agreements wherein applicant assumes the liability of others?** ☐ Yes ☐ No

    If yes, attach a list of each entity that has requested to be named as an additional insured and the type of service(s) applicant provides.

32. **Any other premises or operations exposures not stated in this application?** ☐ Yes ☐ No

    If yes, attach a complete description and underwriting/rating information.

33. **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, advise date and details: _____

    _____

34. **Additional Insured Information:**

Name	Address	Interest

35. 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: _____

36. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies? ☐ Yes ☐ No

If yes, describe: _____

37. Does applicant have other business ventures for which coverage is not requested? ☐ Yes ☐ No

If yes, explain and advise where insured: _____

38. Schedule of Hazards:

Loc. No.	Classification Description	Class. Code	Exposure	Premium Basis (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other

39. Prior Carrier Information:

	Year:	Year:	Year:	Year:	Year:
Carrier					
Policy Number					
Coverage					
Occurrence or Claims Made					
Total Premium	$	$	$	$	$

40. 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 five years. ☐ Check if no losses last five years.

Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claim Status (Open or Closed)
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

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. **Not applicable in Nebraska, Oregon and Vermont.**

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: 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 in the third degree.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: 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.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO OHIO APPLICANTS: Any person who knowingly and with intent to defraud any insurance company 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.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FRAUD WARNING (Applicable in Tennessee, Virginia 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.

NOTICE TO RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW YORK APPLICANTS (Other than automobile): 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: _____

PRODUCER'S ADDRESS: _____

PRODUCER'S LICENSE NUMBER: _____

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.