



PROFESSIONAL and GENERAL LIABILITY APPLICATION ADULT DAY CARE CENTER (Edition 06.2026)

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Location Address: _____
(If multiple locations exist, please complete a separate application for each location)
4. Telephone Number: _____ Website: _____ Date Established: _____

Section 2: Coverage Requested

5. Effective Date: _____
Liability Limits: \$ _____ / \$ _____
Deductible: \$ _____

Section 3: Financial Information and Business Details

6. Gross Receipts (Past 12 Months): \$ _____
7. Estimated Gross Receipts (Next 12 Months): \$ _____
8. Funding is: Medicare _____% Medicaid _____% Private Pay _____% Charitable _____%
9. Does the applicant have any ancillary operations not stated above? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No
10. Is the applicant engaged in, owned by, associated with, or controlled by any other businesses? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No
11. Entity Type: ☐ Corporation ☐ Individual ☐ LLC ☐ Partnership ☐ Other: _____
12. Status: ☐ For Profit ☐ Non-Profit

Section 4: Services Provided

13. Is the facility licensed by the state? ☐ Yes (Please attach a copy of the license)
☐ No (Please explain _____)
14. Has the license ever been revoked? ☐ Yes (Please explain _____)
☐ No

15. How many years of management experience do you have operating an adult day care facility? _____
16. Please provide the facility's days and hours of operation: _____
17. Full description of services provided: _____
18. Do you have a scheduled plan of activities for each day? ☐ Yes ☐ No
19. a) Licensed capacity (Maximum number of adults allowed): _____
- b) Average daily adult attendance: _____
- c) Client age range: _____
- d) Number of developmentally disabled clients: _____
- e) Number of clients requiring wheelchairs or walkers: _____
- f) Number of clients diagnosed with Dementia and/or Alzheimer's disease: _____
20. State Regulatory Compliance:
- a) Are written emergency procedures required under state regulations? ☐ Yes ☐ No
- b) Does the state mandate maximum staff-to-client ratios?
If Yes, indicate the required ratio: _____ ☐ Yes ☐ No
- c) Has the facility been cited for non-compliance with any regulatory standards?
If Yes, attach copies of all citations and inspection findings. ☐ Yes ☐ No

Section 5: Staffing

21. Employee and Independent Contractor Details:

- a) List the **NUMBER** and type of **EMPLOYEES**:

EMPLOYEES	FULL-TIME	PART-TIME	EMPLOYEES	FULL-TIME	PART-TIME
Administrator / Manager			Physician		
Caregiver / Home Health Aide			Nurse Practitioner /Physician Assistant		
CNA			Social Worker / Counselor		
Registered Nurse			Therapist		
LPN/LVN			All Others (Describe):		

- b) List the **NUMBER** and type of **INDEPENDENT CONTRACTORS**: ☐ If None

INDEPENDENT CONTRACTORS	FULL-TIME	PART-TIME	INDEPENDENT CONTRACTORS	FULL-TIME	PART-TIME
Administrator / Manager			Physician		
Caregiver / Home Health Aide			Nurse Practitioner /Physician Assistant		
CNA			Social Worker / Counselor		
Registered Nurse			Therapist		
LPN/LVN			All Others (Describe):		

22. Are all individuals listed on Q21 subject to licensing requirements properly licensed?
(If No, attach details) ☐ Yes ☐ No
23. Are you seeking coverage under this proposed insurance for the independent contractors?
If No, is coverage at equal or greater limits maintained by each independent contractor? ☐ Yes ☐ No
☐ Yes ☐ No
24. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists, or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No
If Yes, provide required limits: \$_____ / \$_____

Section 6: Employee Screening / Controls

25. a) Do you conduct pre-employment screening and investigation? ☐ Yes ☐ No
b) Do you have a written incident/occurrence reporting policy and procedures? ☐ Yes ☐ No
26. Check all the following that are collected, verified, and maintained for each staff member during the hiring process:
☐ Applications/Resumes ☐ Criminal Background Checks ☐ Drug Testing
☐ Professional References ☐ Education/Training/Competence
27. Is the applicant accredited, certified, licensed, or a member of any professional association or governing body? ☐ Yes ☐ No
If Yes, describe: _____
28. Are employees up to date on any training required by the state or other governing body, and is proof of this required training kept on file at the facility? ☐ Yes ☐ No

Section 7: Safety, Accessibility, and Security

29. Is the facility accessible for individuals with disabilities (e.g., ramps, handrails, grab bars)? ☐ Yes ☐ No
30. Does each location have a minimum of two wheelchair-accessible exits? ☐ Yes ☐ No
31. Do you have a written emergency evacuation plan in place? ☐ Yes ☐ No
If Yes, how frequently are drills conducted?
☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Other (Please specify): _____
32. Does each location have a minimum of two functional exits? ☐ Yes ☐ No
33. Are lighted exit signs and emergency lighting installed in all common areas? ☐ Yes ☐ No
34. Are emergency exits clearly marked? ☐ Yes ☐ No
35. Are all medications stored in a locked area when not in use? ☐ Yes ☐ No

36. Does the facility control the following:

a) Entry to the premises?

☐ Yes ☐ No

b) Exit from the premises?

☐ Yes ☐ No

c) Is an entry code required to activate doors for both entry and exit?

☐ Yes ☐ No

37. Please describe any additional safety or security measures in place: _____

Section 8: Regulatory and Inspection

38. Disclosure of Disciplinary or Legal History:

Attach a detailed explanation for any **YES** answers below:

Has the applicant or have any of the employees:

a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?

☐ Yes ☐ No

b) Ever been convicted of any act committed in violation of any law or ordinance (other than traffic offenses)?

☐ Yes ☐ No

c) Ever been treated for alcoholism or drug addiction?

☐ Yes ☐ No

d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms, or voluntarily surrendered?

☐ Yes ☐ No

Section 9: Insurance History

Currently valued loss runs for all prior coverage are required.

39. Professional Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a **claims-made** policy, provide retroactive date: _____



40. General Liability Coverage – Last 5 Years: (If none, state none) _____

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

Section 10: Claims and Incidents

41. Has any insurer canceled or refused to renew similar insurance in the past 5 years?
(If Yes, attach details) ☐ Yes ☐ No

42. Has any claim been made against the insured or its employees that would be covered by this
policy in the past 5 years? ☐ Yes ☐ No

If Yes, please attach a completed Huntersure Claims Supplement (one for each claim or incident reported)

43. Is the applicant aware of any circumstances that may result in a claim against the insured or its employees
that would be covered under this policy? (If Yes, attach details) ☐ Yes ☐ No

Signature and Attestation

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date, time stamp, and originating email address.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)

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