JAMES RIVER INSURANCE	**James River Insurance Company and its Subsidiaries** 6641 West Broad Street, Suite 300 Richmond, VA 23230	**Adult Daycare Supplement Application (Submitted with AH General App)** **ALLIED HEALTHCARE Division** Email to AH@jamesriverins.com or, Fax to 804-420-1054

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

ADULT DAYCARE SUPPLEMENT APPLICATION

Applicant Name: _____

GENERAL INFORMATION:

1. Number of attendees (licensed): _____
   Number of attendees (average attendance): _____

2. Are you currently licensed for operation by the proper regulatory authorities? ☐ Yes ☐ No

3. Is the license conditional? ☐ Yes ☐ No – please explain _____

Attendees Served	Number of:
Seriously mentally impaired (Alzheimer's)	
Somewhat mentally impaired (senile dementia)	
Elderly but mentally & physically fully functional	
Developmentally Disabled	____mild _____ moderate ____profound
Non-Ambulatory	____wheelchair bound
Mental Health Diagnosis	
AIDS/HIV	
Other (*describe*)	
Ages of clients: [ ] under 18 [ ] 18-35 yrs. old [ ] 36-50 yrs. old [ ] 51-65yrs. old [ ] over 65	

4. What precautions are taken to keep track of patients? _____

5. Sign out procedures? ☐ Yes ☐ No

6. Alarms on doors to prevent clients from wandering from residence? ☐ Yes ☐ No
   Elopements in the past three years (provide details):_____
   _____

7. Are any medications administered? ☐ Yes ☐ No

   Please describe:_____

8. Is the insured a: ☐ Building Owner ☐ Tenant ☐ General Lessee

9. Construction of building: _____

10. Year built: _____

11. Number of floors:_____

12. Age and type of wiring: _____

13. Number of fire extinguishers: _____

14. Is the building sprinklered? ☐ Yes ☐ No

15. Smoke detectors? ☐ Yes ☐ No

16. Local or Central Station fire alarm? (circle one) ☐ Yes ☐ No

Staff	Number	Staff	Number
RN		Psychologists	
LPN		Therapists	
Nurse Aids		Counselors/Social Workers	
MD		Other (describe)	

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In 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.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to James River Insurance Company and its Subsidiaries, 6641 West Broad Street, Richmond, VA 23230.

Applicant's Name:	Signature
Title:	Date:

