



APPLICATION INSTRUCTIONS SOBER LIVING /HALFWAY HOUSE LIABILITY INSURANCE PROGRAM

In order to provide you with a coverage proposal you will be required to complete this application in full and submit with an authorized signature.

If you want to include multiple locations on a single policy, please provide the total numbers of beds for ALL locations in question 7. Question 15 is to be completed for EACH location. You can make a copy of the form or print additional copies to complete question 15 for each location insured. If you want building, business personal property or loss of income coverage, question 15 will allow you to indicate so for each location.

If you are required to be licensed, a copy of your current state license is required

A copy of your emergency plan is required

If you have insurance now and are replacing that coverage, a copy of your loss history is required. You will need to make a written request to your current insurance professional for the last 5 years or period of operation, whichever is less.

In addition to the application there are two other forms to be signed, the D1 form required by the State of California when using an approved California non admitted insurance carrier and the Federal Terrorism form.

The following is a checklist of all required documents:

- 1. completed and signed application**
- 2. signed supplemental forms**
- 3. your state license (if you are required to have a license)**
- 4. Emergency Plan**
- 5. Prior Carrier Loss history**

Please fax or email all the documents to 619 287 8921 or to kevin@dahlkeinsurance.com. Upon receipt I will contact you to confirm the application information and answer any questions you may have.

After approval, a proposal including policy terms and conditions will be forwarded by email or fax to you. This will include costs and payment options. All policies are annual from the date of binding.

No coverage is in force until notified in writing by my office that coverage has been bound, your policy number and the effective date of your coverage.

Liability Application
 For
 Sober Living Facilities

1. Name of Applicant _____
 Mailing address _____
 City _____ State _____ Zip _____

Applicant's Web Site address _____

Date established _____ Phone # for inspection _____ Agent phone # _____

2. Individual Corporation Partnership Professional Association Non-profit Corporation
 Other (Explain) _____

3. List all names which you or the corporation has operated under during the past 4 years, if different from above

3a. Is applicant engaged in, owned by, associated with or involved in any other enterprise? Yes No
 If yes, provide details _____

4. Is facility run by an outside management company? Yes No
 If yes, describe contractual relationship _____

4a. Do you provide consultant services for or manage any other facilities? Yes No
 If yes, describe _____

5. List all losses and amounts paid or reserved that have been incurred by these entities. Add pages, if needed.

Year	Insurance Company	Policy Number and Premium	Loss Paid & Reserved	Loss Description

6. Is there liability coverage currently in force? Yes No
 If so, attach copies of currently valued (within last 3 months), hard copy, company loss runs for the last 5 years if applicable.
 _____ State license required for operations and copy attached
 _____ State license not required for operations

7. _____ Licensed bed capacity

8. Has license ever been revoked or suspended? Give details: Yes No

9. If services are offered other than Sober Living / Halfway House explain fully the services offered

10. # of residents by age 0-18 years _____ Over 18 years _____

11. Indicate total number of employed personnel: _____

12. Total number and types of independent contractors (if none go to question 13): _____

12a. (A) MD's _____	12b Are any required to maintain their own professional coverage? _____	Yes	No
(B) RN's _____	Limits required? _____		
(C) LPN's _____	How is coverage verified? _____		
(D) Nurses Aides _____			
(E) Psychologists _____			
(F) Therapists _____			
(G) Counselors _____			
(H) Other (specify) _____			

13 Are background checks made with all prior employers and educational institutions? Yes No
 Does background check include Police record? Yes No

(If either answer is "No", refer risk to Company.)

14. How many residents do you have of the following types? Do not count same patient in more than one

1. Seriously mentally impaired (e.g. Alzheimer's, senile) _____
2. Skilled Care _____
3. Intermediate Care _____
4. Somewhat mentally impaired (e.g. mentally challenged) _____
5. Aged but mentally and physically fully functional _____
6. Drug or alcohol detoxification residents _____
7. Drug or alcohol rehabilitation residents _____
8. Has a communicable disease (e.g. AIDS) _____
9. Other - specify _____

Totals (Totals must not exceed total number of patients.) _____

15 LOCATION BUILDING INFORMATION: **If more than one location, print this page and complete this section for each location**

Location Address: _____

Do you own this building?	Yes	No	Is coverage requested on building?	Yes	No
Loss of income coverage amount?	_____ (Total annual locations receipts)				
Construction type: Frame, Masonry, Steel	_____		Number of stories?	_____	Year built? _____
Built as a nursing home?	Yes	No			
Has an emergency evacuation plan been prepared?	Yes	No			
Are all rooms and halls equipped with smoke detectors?	Yes	No			
Is building equipped with fire alarm?	Yes	No	→ Central Station	Yes	No
Is smoking permitted?	Yes	No			
Are there designated smoking areas?	Yes	No			
Is building sprinklered?	Yes	No	If partially, what percentage?	_____	
What is the total square footage of the building?	_____				

SWIMMING POOLS (If none) N/A

Number of swimming pools?	_____	Is building a: Single Family Home?	Yes	No
If a single family home, is pool fenced with a self closing safety gate?			Yes	No
Do all doors leading to pool area have child proof locks / controls?			Yes	No

16 Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? If yes, please provide details. Yes No

17 Has applicant, or any other person for whom coverage is being requested, had any liability application denied, If yes, provide details. Yes No

18 INDICATE LIMITS OF INSURANCE REQUESTED:

1,000,000 per occurrence, 2,000,000 aggregate

1,000,000 per occurrence, 3,000,000 aggregate

Hire and Non Owned Auto Liability

500,000 per any one Accident

1,000,000 per any one Accident

Decline Coverage

Abuse & Molestation Coverage of 50,000 per Occurrence / 100,000 Aggregate

Decline Coverage

Assault & Battery Coverage of 50,000 per Occurrence / 100,000 Aggregate

Decline Coverage

19 Effective Dates Desired: From _____ To _____

IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS 20 THROUGH 23. If not desired, please sign application at bottom of page.

20 Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? Yes No
If yes, provide details. _____

21. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? Yes No
If yes, provide details. _____

22 Has any facility that you have been associated with in the past ever had a molestation allegation or claim brought against it while you were there? Yes No
If yes, provide details. _____

23 Does your facility do background checks on all employees and volunteers? Yes No
Describe types of checks done (prior employer, police, _____)

FRAUD NOTICE: 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 purposes 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.

Applicant's Signature: _____ Date: _____

Title: _____ Producing Agent: _____

NOTICE:

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: www.insurance.ca.gov.**
- 5. FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
- 6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER’S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.”**

Date: _____
Insured: _____

Possibility Of Additional Or Return Premium. The premium for certified acts of terrorism coverage is calculated based in part on the federal participation in payment of terrorism losses as set forth in the Act. The federal program established by the Act is scheduled to terminate at the end of 12/31/07 unless extended by the federal government. If the federal program terminates or if the level or terms of federal participation change, the estimated premium shown in **(B)** of above may not be appropriate.

If the policy contains a Conditional Exclusion, continuation of the coverage for certified acts of terrorism, or termination of such coverage, will be determined upon disposition of the federal program, subject to the terms and conditions of the Conditional Exclusion. If the policy does not contain a Conditional Exclusion, coverage for certified acts of terrorism will continue. In either case, when disposition of the federal program is determined, we will recalculate the premium shown in **(B)** above and will charge additional premium or refund excess premium, if indicated.

If we notify you of an additional premium charge, the additional premium will be due as specified in such notice.

Policyholder/Applicant's Signature

NAUTILUS INSURANCE COMPANY
Insurance Company

Print Name

Policy Number

Date

Named Insured