Commonwealth Underwriters Ltd.
P.O. Box 5441 Richmond, VA 23220
Phone: 800-396-6226
Fax: 888-359-6994
www.commund.com

ALLIED MEDICAL ADULT DAYCARE SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION: Hours of operation:_____

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

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

3. Is the license conditional? ☐ No ☐ Yes
   If "Yes," please explain:_____

Attendees	Number of:
Seriously mentally impaired (Alzheimer's)	
Somewhat mentally impaired (Senile)	
Aged by mentally & physically fully functional	
Developmentally Disabled	_____mild _____moderate _____profound
Non-Ambulatory	_____wheelchair-bound
Mentally Ill/Disabled	
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? ☐ No ☐ Yes

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

7. Are any medications administered? ☐ No ☐ Yes
   If "Yes," please describe:_____

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

9. Construction of building: _____

10. Year built: _____/_____/_____ Number of floors_____

11. Age and type of wiring: _____

12. Number of fire extinguishers:_____ Is the building sprinklered? ☐ No ☐ Yes

13. Smoke detectors? ☐ No ☐ Yes

14. ☐ Local or ☐ Central station fire alarm?

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

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

DECLARATION AND SIGNATURE:
The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature	Sub-Producer
Title/Date	Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.