Colorado Host Home Insurance Program

COLORADO HOST HOME PROVIDER INSURANCE APPLICATION

Coverage Term: 03/01/2010 through 03/01/2011

Application Information

Section 1

Full Name: ____(Do not put in your consumer(s) name)

Mailing Address: ______________________________ City: ______________St: ____Zip: _______

Host Home Address: (Same as above) Yes: _______ (If not please complete the Host Home Address)

Host Home Address: ____________________________City: ______________St: ____Zip: ______

Phone Number: _______________ Cell Phone Number: ______________

Email Address: ____

Agency Placing Consumer(s): ____

Agency Phone No: _________________

Section 2: Underwriting Questions

1. Has the organization [CCB or SPO] visited your Host Home (This is a state requirement)? Yes:___No: ___
2. Will the organization [CCB or SPO] be making periodic visits to your Host Home (This is a state requirement)?

   Yes:_____ No: _____
3. Have you authorized the organization [CCB or SPO] to initiate a background check on your and anyone 18yrs of age or older living in your home (This is a state requirement)? Yes: _____ No: _____
4. How many years of experience have you had as a Host Home Provider? __________
5. a. Do you own your residence? Yes: ___No: ___ Do you carry Homeowners Insurance? Yes: ___ No: ___

   b. Do you rent your residence? Yes: ____ No: ____ Do you carry Renters Insurance? Yes: ____ No: _____
6. Within the last 5 years, have you been subject to any disciplinary action brought against you as a Host Home Provider by a court, Community Centered Board, SPO or organization? Yes:_____ No: _____
7. Have you had a claim filed against you or an allegation of negligence as a Host Home Provider?
   Yes:_____ No: _____
8. Are you aware of any incident in the past which could result in a claim being filed against you?
   Yes: ____ No: ____
9. Has any insurance company cancelled or non-renewed similar coverage? Yes:_____ No: _____
10. Describe any training and/or certification you have received to qualify as a provider: (Check all that apply)

    First Aid: _______ CPR: _______ Abuse Neglect Training: ________
    Other: ____
11. Is your consumer developmentally disabled? Yes: _____ No: _____

    Please indicate the number of consumers in each age range:

    18 – 64 [ ] (State the number)

    65 Plus [ ] (State the number)

PLEASE SEE REVERSE SIDE

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** If you have any consumers 65+, the next six questions MUST be answered**

1. Is your consumer ambulatory? (Can they walk on the own without assistance?) Yes: ____ No: ____
2. Does your consumer require assistance in order to walk all or most of the time? Yes: ____ No: ____
3. Is your consumer in a wheelchair all or most of the time? Yes: ____ No: ____
4. Is your consumer confined to a bed? Yes: ____ No: ____
5. Does your consumer require medical or nursing care on a daily basis? Yes: ____ No: ____
6. Can your consumer care for themselves? If not what things must you do for your consumer on a daily basis? (Check all that apply)
   Cook: ______ Bathe: ______ Clean: ______ Administer Medications: ______

ALL PREMIUMS INCLUDE TAXES AND FEES

Write in the Dollar Amount for the Number of Consumers

1 Consumer	$265.00	
2 Consumer(s)	$470.00	
3 Consumer(s)	$675.00	
	SUBTOTAL AMOUNT DUE:	
IF YOU HAVE ANY CONSUMER OVER 65 YEARS OLD ADD $75.00		
	TOTAL AMOUNT DUE:	

FOR EXAMPLE

1 Consumer over 65 your premium:
$265 + 75 = $340

2 Consumers with any or all Consumers over 65 years old your premium:
$470 + $75 = $545

3 Consumers with any or all Consumers over 65 years old your premium:
$675 +$75 = $750

THE APPLICANT DECLARES THE ABOVE STATEMENTS AND REPRESENTATIONS ARE TRUE AND CORRECT AND THAT NO FACTS HAVE BEEN SUPPRESSED OR MISSTATED. THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE COMPANY TO SELL NOR THE APPLICANT TO PURCHASE THIS INSURANCE, BUT ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPEPRESENTATIONS MADE IN THIS APPLICATION AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

FURTHERMORE, THE APPLICANT UNDERSTANDS THAT ANY COVERAGE PROVIDED BY THE COMPANY WILL BE PART OF A COLORADO HOST HOME INSURANCE PROGRAM WITH A $1,000,000 LIMIT OF LIABILITY PER CLAIM AND A MAXIUMUM POLICY AGGREGATE LIMIT OF $5,000,000 (Effective 3/1/2010 – 3/1/2011). THEREFORE, IT IS POSSIBLE THAT CLAIMS ASSOCIATED WITH OTHER COLORADO HOST HOMES MAY PARTIALLY REDUCE OR ENTIRELY ELIMINATE LIMITS OF LIABILITY AVAILABLE TO YOU. IT IS AGREED THAT SUCH COVERAGE AS IS AFFORDED BY SECTION 102(1) OF THE TERRORISM RISK INSURANCE ACT OF 2002 IS INCLUDED FOR NO PREMIUM CHARGED.

APPLICANT HAS READ AND UNDERSTANDS THE ABOVE INFORMATION AND REALIZES THERE WILL BE NO CANCELLATION REFUNDS

HOST HOME PROVIDERS SIGNATURE: ____ DATE: _________

PAYMENT OPTIONS

You may complete your application for RENEWAL ONLINE at www.careassociation.net, credit or debit cards are accepted. If you need assistance with online applications please contact our office at 303-333-0375. If you are submitting your application via mail please attached a CHECK OR MONEY ORDER made payable to Colorado CARE Association. Any returned checks will be assessed at $25.00 charge plus the premium payment. NO CANCELLATION REFUNDS will be issued should contracts change mid-year. All applicants must be approved prior to binding coverage. Certificates of Insurance will be issued upon approval. If approval is denied, your payment will be returned to you within 15 days of denial.