

**RESPITE CARE – IN HOME CARE – COMMUNITY ACCESS
INDIVIDUAL INSURANCE APPLICATION
CARE ASSOCIATION**

**THIS APPLICATION IS FOR A SINGLE INDIVIDUAL CARE PROVIDER
Application Valid from 03/01/2012 through 03/01/2013**

Section 1

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

Trade Name: (If Applicable) _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Email Address: _____

Agency Placing Consumer(s): _____

Agency Phone No: _____

Is the Host Home Address: (Same as above) Yes: _____ No: _____

Host Home Address: _____ City: _____ St: _____ Zip: _____

Phone Number: _____ Cell Phone Number: _____

Section 2: Underwriting Questions

1. Do you provide overnight respite services to developmentally disabled individuals? Yes: _____ No: _____

If yes, answer the following questions:

*Do you provide overnight respite in your DD clients' home? Yes: _____ No: _____

*Do you provide overnight respite in your home? Yes: _____ No: _____

• If yes do you have home owners or renters insurance? Yes: _____ No: _____

*Do you provide these services for individuals under 18 Years of age? Yes: _____ No: _____

*Do you provide these services for individuals over 64 Years of age? Yes: _____ No: _____

2. Do you provide in-home support to a DD individual(s) in their home? Yes: _____ No: _____

• If yes, is the in home support non-medical? Yes: _____ No: _____

*Do you provide these services for individuals under 18 Years of age? Yes: _____ No: _____

*Do you provide these services for individuals over 64 Years of age? Yes: _____ No: _____

3. Do you provide community access or other support services in the community? Yes: _____ No: _____

*Do you provide these services for individuals under 18 Years of age? Yes: _____ No: _____

*Do you provide these services for individuals over 64 Years of age? Yes: _____ No: _____

4. How many years of experience have you had as a care provider for individuals with special needs?

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|---|------------------------------|-----------------------------|
| Have you authorized the organization [CCB or SPO] to initiate a background check on you and anyone 18yrs of age or older living in your home (This is a state requirement)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Within the last 5 years, have you been subject to any form of <u>disciplinary action</u> as a Host Home Provider by a Court, a Community Centered Board, a Service Provider organization or any other organization you are contracted with? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had an allegation of Mistreatment, Abuse, Neglect or Exploitation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Yes, did it result in <u>substantiated</u> Mistreatment, Abuse, Neglect or Exploitation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had a law suit filed against you as a Host Home Provider? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you aware of any incident in the past which could result in a claim being filed against you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has any insurance company cancelled or non-renewed similar coverage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| PLEASE EXPLAIN ANY YES ANSWERS: (Attach additional pages if necessary) | | |
| 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: _____ | | |

****PREMIUM INCLUDES TAXES AND FEES****

General & Professional Liability Insurance Total Premium Due: \$275.00
 \$1,000,000 Per Occurrence LimitIncluded
 \$5,000,000 Aggregate LimitIncluded

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 MASTER INSURANCE PROGRAM WITH A \$1,000,000 LIMIT OF LIABILITY PER CLAIM AND A MAXIMUM POLICY AGGREGATE LIMIT OF \$5,000,000 (Effective 3/1/2012 – 3/1/2013). THEREFORE, IT IS POSSIBLE THAT CLAIMS ASSOCIATED WITH OTHER CARE PROVIDERS 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

APPLICANT 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 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.