TDC Specialty Underwriters
TDC GROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

MEDICAL FACILITIES ADULT DAYCARE SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

PLEASE SUBMIT WITH MEDICAL FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION

1. Applicant Name (as identified in the Liability Insurance Application for proposed insurance):

2. Is this a: Social Day Care: ☐ OR a Medical Day Care: ☐

3. What are the hours of operation:

4. Number of attendees (licensed) _____ Number of attendees (average attendance) _____

5. Are you currently licensed for operation by the proper regulatory authorities? ☐Yes ☐No
(Please provide a copy of license and state inspection)

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

7. Please provide the number of attendees in your facility:

Attendees	Number of
Seriously mentally impaired (Alzheimers)	
Somewhat mentally impaired (Senile)	
Aged but mentally & physically fully functional	
Developmentally Disabled	_____ Mild _____ Moderate _____Profound
Non-Ambulatory	_____ Wheelchair-bound _____ Walker
Mentally Ill/Disabled	
AIDS/HIV	
Other (describe): _____	
% of clients by age (total must be 100%): ___under 18 ___ages 18-35 ____ ages 36-50 ____ ages 51-65 ___over 65	

8. What precautions are taken to keep track of attendees?

9. Do you have sign out procedures? ☐Yes ☐No

10. Are there alarms on doors to prevent attendees from wandering from the residence / facility? ☐Yes ☐No

11. How many elopements have there been in the past three years (please provide details):

12. Are any medications administered in your facility? ☐Yes ☐No
If "Yes," please describe:

13. Who administers the medications?

14. Where are the medications stored?

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

16. Please describe the construction of the building:
    a. Year built: _____
    b. Number of floors: _____

17.	How many fire extinguishers are in the building? _____	
18.	Is the building sprinklered?	☐Yes ☐No
19.	Are there smoke detectors in the building?	☐Yes ☐No
20.	Is the fire alarm: ☐Local or ☐A Central Station Alarm	

21. Please provide information on the number of staff in your facility:

Staff Type	Number
RN	
LPN	
Nurse Aids	
MD	
General Care Giver	
Certified Medication Aide	
Therapists	
Counselors/Social Workers	
Other (describe): _____	

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	