GenStar

Residential Location Supplemental Application

Applicant's Instructions:

Answer all questions. If the answer to any question is NONE, please state NONE.
Do not use N/A or Not Applicable.

Please fill out a separate Residential Location Supplemental Application for each Residential location.

Applicant:

Proposed Effective Date: _____

Full name of all entities of the applicant: _____

_____

Name of operation at this location (if different than above):

_____

Address: _____

Operations:

Type of Facility: ____Prison ____Jail ____Boot Camp ____Restitution Center ____Halfway House

____Community Center Other _____

Age group of occupants: ____Adult ____Juvenile Gender of Occupants: ____Male ____Female

Occupant Status: Convicted Felon____ Convicted Misdemeanor____ Pre-Trial Detainees____

INS Detainees ____ US Marshall Detainees ____ Other _____

What percentage of occupants is directed to you and your facility by the criminal justice system? : _____%

Does applicant own a 50% or greater interest in this operation? Yes ____ No ____

Is this location accredited by the American Correctional Association (ACA)? Yes ____ No ____

Residential Facility Information:

Total Square Footage_____ Certified Capacity _____ Year Built _____

Year of Latest Renovation _____ Average Length of Stay _____ Number of Cells _____

Total Number of Beds _____ Average Daily Population _____

Are occupants permitted to leave the facility unescorted? Yes ____ No ____

Please advise the number of escapees during the last 5 years: _____

Can you refuse to admit a potential occupant? Yes ____ No ____

Facility Incidents:

Number of Assaults (Including Sexual):

Occupant vs. occupant? _____ Occupant vs. Staff? _____ Staff vs. Occupant? _____

Number of Deaths:

Occupant? _____ Staff? _____ Visitor? _____

For all incidents resulting in death, please provide a description of the incident below:

_____

_____

_____

Have there been any attempted suicides in the past 5 years? Yes ____ No ____

If yes, please specify how many? _____

Have there been any allegations or claims of excessive or inappropriate force over the past 5 years? Yes ____ No ____

If yes, please specify how many? _____

Have there been any allegations or claims of sexual misconduct over the past 5 years? Yes ____ No ____

If yes, please specify how many? _____

Are medical records for occupants received within 24 hours of admittance? Yes ____ No ____

If no, please confirm procedures and standard timeframe allowed in obtaining these records:

_____

_____

Do you transport occupants of your facility? Yes ____ No ____

If yes, please fill out the Offender Transportation Supplemental Application and forward.

Do you currently, or have you anytime during the past 5 years, operated under a court order or consent decree?

Yes ____ No ____

If yes, have there been any repeat violations of the court order or consent decree? Yes ____ No ____

Healthcare (For this location only):

Please check the classification of services which best describes the health care services provided by you:

Clinic, Dispensary, Infirmary____ Mental or Psychopathic Treatment Center____ Medical or Surgical Center____

Drug or Substance Abuse Treatment Center____ Other _____

Number of Health Care beds? _____ Square Footage of Facility _____

Medical Personnel:

Please list all physicians, physician assistants and psychiatrists (all employed, volunteer or contracted)

1.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

2.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

3.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

4.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

5.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

Please attach another sheet if space provided above is insufficient. Also, please note that no Medical Malpractice coverage is provided by this policy for Physician's, Physician's Assistants or Psychiatrists.

Employees:

	YES	NO	# OF FULL TIME	# OF PART TIME
Facility Administrators	☐	☐	_____	_____
Wardens / Assistant Wardens	☐	☐	_____	_____
Correctional Officers / Guards	☐	☐	_____	_____
Psychologist's	☐	☐	_____	_____
Pharmacist's	☐	☐	_____	_____
Physicians, Psychiatrists or Physician's Assistants:	☐	☐	_____	_____
Counselors:	☐	☐	_____	_____
Registered Nurses / L.P.N.'s	☐	☐	_____	_____
Clerical Staff / Maintenance	☐	☐	_____	_____
Other:	☐	☐	_____	_____

Please describe all employees that are "Other": _____

Do any of the above employees carry their own Errors and Omissions Insurance? Yes ____ No ____

If yes, please identify whom and what limits are carried: _____

Life Safety / Risk Management:

Number of stories: _____

Construction: Frame ____ Masonry____ Non-Combustible ____ Fire Resistive ____ Masonry Non Combustible____

Are all doors and windows alarmed? Yes ____ No ____

Distance from facility to the nearest fire station? _____

Are there heat sensors on each floor? Yes ____ No ____

Are there smoke detectors on each floor? Yes ____ No ____

Is there a ventilation system servicing all offender areas with high exhaust capacity Yes ____ No ____

If yes, does ventilation system have heat sensors? Yes ____ No ____

If yes, does ventilation system have smoke sensors? Yes ____ No ____

If yes are at least two vents accessible from every floor? Yes ____ No ____

Does the facility have a sprinkler system? Yes ____ No ____

If yes, is the sprinkler system specifically configured to address all high exposure areas (i.e. laundry, storage closets, kitchen areas etc.)? Yes ____ No ____

If yes, is the sprinkler system inspected and tagged annually? Yes ____ No ____

Is there an automatic, dry chemical fire suppression system over all cooking surfaces? Yes ____ No ____

If yes, Is the system inspected and tagged annually? Yes ____ No ____

Is there an automatic, dry chemical fire suppression system over all cooking surfaces? Yes ____ No ____

Is there at least one fire alarm per floor or wing that is connected to a central station? Yes ____ No ____

If yes, does the fire alarm signal a distinct sound in the control room? Yes ____ No ____

Are fire alarms connected to smoke detectors? Yes ____ No ____

Are there a sufficient number of marked fire blanket containers with fire blankets? Yes ____ No ____

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Are all storage closets fitted with at least one-hour fire doors? Yes ____ No ____

Are all designated fire doors equipped with automatic closing devices? Yes ____ No ____

Do all doors open in the direction of a primary fire exit? Yes ____ No ____

Are facility exits marked with illuminated exit signs? Yes ____ No ____

Is there outside access to all floors in the event of an emergency? Yes ____ No ____

Are any flammable liquids are handled at the facility? Yes ____ No ____

If Yes, what liquids? _____

Do offenders have access to flammable liquids? Yes ____ No ____

If Yes, what liquids? _____

Are there designated smoking areas in the facility? _____

If yes, please describe: _____

Are any combustible substances stored in offender areas? Yes ____ No ____

If Yes, please describe: _____

Is all of the bedding in offender areas fabricated of fire retardant and non-toxic materials? Yes ____ No ____

Is smoking allowed in offender bed areas? Yes ____ No ____

Are electric flame-less wall lighters used? Yes ____ No ____

Are all trashcans constructed of durable metal? Yes ____ No ____

Are all offender areas equipped with flush mounted, tamper proof security lights? Yes ____ No ____

Does facility have self-contained oxygen masks located in all critical areas? Yes ____ No ____

Is all electrical wiring of a three phase grounded type? Yes ____ No ____

Is all electrical wiring protected by conduit with no open runs? Yes ____ No ____

Is there a backup and/or auxiliary electrical system? Yes ____ No ____

Is there a master-lock system that could open all of the offender cell doors simultaneously in the event of an emergency? Yes ____ No ____

Surveillance Systems: Booking Area Audio____ Video____ None____

Cell Areas Audio____ Video____ None____

Sally Port Audio____ Video____ None____

In the event of an evacuation, is a temporary housing plan in place? Yes ____ No ____

Who (name and title) is responsible for the implementation and monitoring of emergency and life safety programs at the facility?

_____

What formal training or expertise does the above individual have in regard to emergency situations?

_____

_____

_____

Are all employees instructed on actions to be taken in the event of a life safety emergency? Yes ____ No ____

Is there a log kept on all reported life safety incidents? Yes ____ No ____

Are specific personnel assigned to regularly inspect all life safety or fire protection equipment? Yes ____ No ____

Are defective conditions noted during inspections always corrected within thirty (30) days of notation? Yes ____ No ____

Is facility staffed with at least one (1) full time employee responsible for building maintenance? Yes ____ No ____

Is the facility regularly inspected any of the following groups:

State Corrections Officials?. Yes ____ No ____ Date of last inspection: _____

Fire Inspectors? Yes ____ No ____ Date of last inspection: _____

Department of Health? Yes ____ No ____ Date of last inspection: _____

Please attach a current copy of the resume of the individual in charge of the facility.

Please also attach a copy of the Operations Manual regarding each of the following:

- **Administration / Security of Medicine**
- **Emergency Evacuation Procedures**
- **Inmate Grievance Procedures**
- **Intake, Screen & Classification**
- **Medical Treatment**
- **Strip Searches**
- **Suicide Prevention and Control**
- **Visual observation of offenders**

FRAUD WARNING

Notice to Applicants of all states except Colorado, New York, and Pennsylvania

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material 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 the person to criminal and civil penalties and denial of insurance benefits.

Notice to Colorado Applicants:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to New York Applicants:
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, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Pennsylvania Applicants:
Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material 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 the person to criminal and civil penalties.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut, and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state. This information applies to General Star National Insurance Company in Connecticut only.

An authorized representative who is an active owner, officer, or partner of your firm must sign this Application within thirty (30) days prior to the policy inception date.

Signature: _____ Title: _____
(Owner, Partner or Officer)

Date: _____

THE APPLICANT UNDERSTANDS THAT COMPLETION OF THIS APPLICATION NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.