WALA Liability Plan – New Business Insurance Application

1. Name of Facility: ____

2. Name of Operator/Owner: ____

3. Facility Address: ____
Street City State Zip

Mailing Address: ____
Street City State Zip

County: ______________ Phone: ______________ Email Address: ______________________

If you have multiple homes/additional licenses or certifications, please complete a separate application for each location

4. Number of years under current ownership: __________

5. Do you rent or own this location? Rent Own

6. WALA Member ID Number: ____________

7. What is your current certification/licensing status? Active Applying

   If Active and Licensed, what is your License Number: ______________

8. Are you in compliance with all the State Requirements and Regulations? Yes No

   If No, list deficiencies and plan of action:

   ____

9. Have you ever had a citation, warning or fine issued against you or your Adult Family Home or CBRF? Yes No

   If Yes, please explain:

   ____

10. Have you ever had your license or certification suspended, revoked or placed under probation? Yes No

    If Yes, please explain:

    ____

11. Have you had any accidents, incidents, lawsuits or insurance claims related to, but not limited to abuse, neglect, violence, medications, care, property, premises or death for your AFH or CBRF in the last three years, regardless if the incident was insured? Yes No

    If Yes, please explain:

    ____

If you answered Yes to questions 9 – 11 and you fail to provide additional details and documentation of these accidents, incidents or insurance claims, your application will be flagged from processing.

12. Total number of licensed or certified beds: _________

    Is/are your resident(s) a relative? Yes No

    If you are certified for a range of beds (ex- 1-2 beds), please use the greater number.

13. Total number of employees: _____________

14. Are employment references and background checks performed on all caregivers prior to hiring? Yes No

15. What is the requested effective date of coverage: _________________

    Note: Coverage is only effective upon acceptance and approval of application and receipt of payment

16. Name and address of funding source/managed care organization with whom you contract:

    ____

17. Does your home have any of the following: Pools ATVs

18. Do you have any animals? Yes No

    If Yes, please describe what types:

    ____

19. Was previous commercial insurance purchased or in place for your AFH or CBRF? Yes No

    If yes, please provide a copy of the declaration page of the commercial insurance policy and loss runs.

    If no, please complete the following:

    I certify there have been no losses or any incidents to my knowledge which may give rise to a loss.

Signature: ____ Date: _____________

Printed Name: ____

Please completed and sign application and return to M3 Insurance along with requested documents and a check or money order for the amount of the total premium due, made payable to M3 Insurance.

M3 Insurance
PO Box 8950
Madison WI 53708

Application, additional documents and payment must be received by M3 within 10 days of the requested effective date of coverage and binding of coverage is subject to final underwriting approval.

Last Updated 12/3/24

INSURANCE APPLICATION WARRANTY

I understand and agree this application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I understand and agree that West Bend Mutual Insurance Company ("WBMIC") or M3 Insurance Solutions, Inc. ("M3") as WBMIC's agent, may confirm responses contained on the application through the State of Wisconsin's licensing and or inspection division, or through the applicable Managed Care Organization's licensing and inspection services. I further understand and agree that failure to provide a true and accurate responses to the foregoing questions may, at the option of WBMIC, result in the voiding of insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to WBMIC any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by WBMIC as may be authorized by law.

Applicant and all owners, employees and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application. I agree to hold M3 harmless of any errors made on this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND WBMIC TO COMPLETE AND/OR ISSUE AN INSURANCE POLICY.

_____________________ Date

_____________________ Applicant Signature

_____________________ Print Name/Title