

JAIL SUPPLEMENTAL APPLICATION

BY COMPLETING THIS APPLICATION, THE APPLICANT IS APPLYING FOR COVERAGE WITH EITHER ARGONAUT INSURANCE COMPANY OR ARGONAUT GREAT CENTRAL INSURANCE COMPANY , A LICENSED INSURER.									
Entity Name						Date			
	Please include a copy of the	ne most curi	rent State Inspect	ion Report.					
I.	UNDERWRITING INFORMA Jail Administrator Name:	Length of Tenure:							
	Jail Administrator Highest Level of Education:								
	Is the entity accredited by ACA?							Yes	S No
	Number of Suicides Last 36 Months: Number of Suicide Attempts Last 36 Months:								
	Jail Medical Services Contracted out?								s 🗌 No
	If Medical Contracted, Contract in Place shifting Medical Malpractice Liability to Contractor							☐ Yes	s 🗌 No
	Jail Type: Linear Podular - Remote Podular - Direct								
	Personnel Type			# Full-ti	me	#	Part-time		
	Jailers/Matrons/Detention (Guards							
	Jailer Turnover	Voluntary	Terminations	Involuntary Ter	minations				
	Last 12 months	,		<u> </u>					
	Last 36 months								
	Maximum State Certified	State Certified Capacity Daily Average		Average Len	Average Length of Stay				
II. POLICIES AND PROCEDURES									
	Policy	Do	You Have Policy	Date of	Date of Last Revision		Frequency of Training		ining
	Use of Force		Yes No						
	Classification		Yes No						
	Use of Restraints		Yes No						
	Suicide Prevention	[Yes No						
	Strip Searches		Yes No						
THIS	SUPPLEMENTAL APPLICA	TION IS INC	ORPORATED BY	REFERENCE IN	TO THE PR	IMARY	APPLICATIO	N	
	LICANT'S SIGNATURE					DATE			

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