COLONY SPECIALTY
Member Argo Group

ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Desired Effective Date: _____
2. Applicant Name: _____
3. Mailing Address: _____
4. City, State, Zip: _____
5. County: _____ 6. Telephone Number: _____
7. Inspection Contact: _____ 8. Website Address: _____
9. Date Established: _____ 10. Years in Business Under Current Management: _____
11. Type of Enterprise: ☐ Corporation ☐ Individual ☐ Partnership ☐ Joint Venture
    ☐ Municipality ☐ In-Patient -Psychiatric
    ☐ Other (describe): _____
12. Enterprise is: ☐ For Profit ☐ Not For Profit
13. Estimated receipts/operating budget for the next twelve (12) months: _____
14. Estimated payroll for the next twelve (12) months: _____
15. Type of Operation:
    ☐ Mental Health Inpatient ☐ Group Home (Non-Elderly)
    ☐ Prison/Jail ☐ Boot Camp ☐ Lock-down Facility ☐ Shelters/Halfway House
    ☐ Alcohol/Drug Detox. ☐ Alcohol/Drug Inpatient ☐ Apartments ☐ Foster Care (children)
    ☐ Independent Living (Elderly) ☐ Assisted Living Facility
    ☐ Other (describe): _____
16. Full description of services rendered: _____

II. CURRENT INSURANCE

This section must be completed for prior acts consideration. Attach a copy of expiring policy declarations page.

1. a. Has Applicant had previous insurance for this enterprise? ☐ Yes ☐ No
   b. If Yes, complete the following for prior three (3) years of general/professional liability coverage:

Name of Carrier	Effective Date	Expiration Date	Limit	Deductible	Premium	Claims Made (CM) or Occurrence?	CM Retroactive Date

III. CLAIMS ACTIVITY AND INCIDENT REPORTING PROCEDURES

1. Claims and Incident Activity

Important Notice: All known claims and/or incidents that could reasonably result in a claim are specifically excluded from coverage. Report all such claims or incidents to your current insurer. Your failure to disclose any claim, or incident that could reasonably result in a claim, may result in the proposed insurance being void and/or subject to rescission.

a. Claims Activity - Please list all claims that have been presented to you or to your past or your current insurer during the past five years. Please continue on a separate sheet of paper if necessary.

Date of Loss	Current Reserve or Paid Amount	Description of Loss	Insurer

b. Incident Activity - Please outline the details below regarding any of the following incidents that have taken place at any of your facilities for which coverage is being requested, but where such incidents have not been reported to any insurer:

Death of a client, patient or resident from other than natural causes;

Injury to a client, patient or resident that required hospitalization;

Incident involving abuse, molestation, sexual assault, rape or improper contact;

Incident that generated a formal complaint or notice from any federal or state regulatory body;

Injury resulting from an elopement or unauthorized absence of a client, patient or resident;

Improper medication or improper dosage resulting in hospitalization; or

Decubitus ulcer(s) first acquired under your care that have reached Stage IV.

_____

_____

_____

_____

_____

1) Are there any other known incidents that could reasonably be expected to result in a claim against the Applicant? ☐ Yes ☐ No

2) Have all known incidents that could reasonably be expected to result in a claim been reported to your current or prior insurer? ☐ Yes ☐ No

2. Risk Management Protocols

a. Are there procedures in place requiring the documentation of all incidents in a written report? ☐ Yes ☐ No

b. Who is responsible for receiving and recording information relating to incidents and reporting them to your insurer?

Name: _____ Title: _____

3. Other

a. Has any license or accreditation ever been suspended, denied or revoked? ☐ Yes ☐ No

b. Please list all professional association(s) in which the Applicant is a member in good standing:

_____

c. Has the Applicant ever had its professional liability insurance policy cancelled or non-renewed? ☐ Yes ☐ No

d. If Yes, please explain: _____

_____

IV. OPERATIONS

1. Indicate current staffing levels:

Staff	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
Administrators				
MD/Physicians				
Nurses				
Homemakers/Nurse Aids				
Psychologists				
Counselors				
Therapists				
Students or volunteers				
Other (describe):_____				

2. Check the hiring procedures that apply or are performed by this operation:

☐ Criminal Background Checks ☐ Verification of certification or professional licensing

☐ Drug screening or testing ☐ Reference Checks

☐ Questioning of employees in their previous involvement as defendants in professional malpractice litigation

3. **Schedule of Physicians** – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

4. List the duties of the physician(s) in 3. above: _____

_____

5. Do you want any listed physician to be covered under the facility's policy? ☐ Yes ☐ No

6. a. Are any drugs or medications administered or prescribed? ☐ Yes ☐ No

b. If Yes, please explain: _____

_____

V. LOCATION INFORMATION

1. **Schedule of Locations:** If more than five locations, please attach a separate sheet of locations.

	Address	Types of Services Provided
# 1		
# 2		
# 3		
# 4		
# 5		

2. a. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? ☐ Yes ☐ No
   b. If Yes, please submit brochure or describe activities: _____
3. a. Are there any firearms on the premises? ☐ Yes ☐ No
   b. If Yes, please describe: _____
   c. Are the firearms locked in a secure place away from the residents? ☐ Yes ☐ No
   d. If No, please describe: _____
4. a. Are there any animal exposures on the premises? ☐ Yes ☐ No
   b. If Yes, are the animal exposures: ☐ Owned ☐ Non-owned?
   c. If Yes, please describe, including number of animals and type/breed: _____
5. a. Are there any lakes, ponds, rivers, pools or other bodies of water on the premises? ☐ Yes ☐ No
   b. If Yes, please describe: _____
   c. Are there any swimming or boating activities? ☐ Yes ☐ No
   d. If there is a pool or body of water, then is it fenced with a self-locking gate? ☐ Yes ☐ No
   e. If there is a pool or body of water, then is there a diving board and/or slide? ☐ Yes ☐ No

VI. COVERAGE REQUESTED

1. Complete and attach the appropriate supplemental application with your submission.
2. Check the coverages and limits that the Applicant would like quoted:
   a. Coverages: ☐ GL ☐ Professional ☐ Excess (Attach Acord App)
   b. Limits: ☐ $100,000/$100,000 ☐ $300,000/$300,000 ☐ $500,000/$500,000
      ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000
3. a. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? ☐ Yes ☐ No
   b. If Yes, at what limits? ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000
      ☐ $250,000/$250,000 ☐ $500,000/$500,000 ☐ Other: _____

Please attach a copy of the following with your submission:

Five (5) years of currently dated loss runs (if in business less than five (5) years, please attach a resume of the owner/director)

Brochure(s) available or other information pertaining to the programs offered

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

Authorized Signature on behalf of Applicant	Sub-Producer
Title/Date	Producer

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.

COLONY SPECIALTY
Member Argo Group

ALLIED MEDICAL LONG TERM CARE ASSISTED LIVING AND NURSING HOME SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Is your facility run by an outside management company? ☐ Yes ☐ No
   If Yes, provide name of company: _____
   If Yes, does the outside management company have their own insurance coverage? ☐ Yes ☐ No
2. Are you engaged in, owned by, associated with or involved in any other enterprises? ☐ Yes ☐ No
   If Yes, please explain:
3. Do you use a binding arbitration contract? ☐ Yes ☐ No
   If Yes, are ALL residents required to enter into a binding arbitration contract prior to moving in? ☐ Yes ☐ No

II. RESIDENT ASSESSMENT

1. Is a nursing assessment conducted for new patients? ☐ Yes ☐ No
   If Yes, who completes pre-admission assessments? ☐ RN ☐ LPN ☐ Other (describe qualifications): _____
   _____
   If Yes, does this assessment include evaluation of:
   ☐ Full body skin breakdown/Decubitus ulcer ☐ Mobility limitations ☐ Cognitive
   ☐ History of prior injuries ☐ Required assistance ☐ Current medications ☐ Wandering Risk
2. What is the system for identifying when a resident needs to be transferred to another level of care (i.e., Nursing Home): _____
   _____
3. How often are residents reassessed? _____
4. Have you denied any admissions? ☐ Yes ☐ No
   If Yes, please indicate how many admissions were denied in the past two years and reason(s) for denial: _____
   _____
5. What system is in place to ensure timely reassessments? _____
   _____

III. RESIDENT CENSUS

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
How many dementia residents (including Alzheimer's)?			
How many residents receiving skilled care?			
How many residents receiving intermediate nursing care?			
How many residents are independently ambulatory?			
How many residents ambulate with assistance?			

	Location 1	Location 2	Location 3
How many residents are in a wheelchair all or most of the day?			
How many residents are bedridden?			
Minimum number of staff on duty during the third shift?			
Indicate number of residents in each age range:	0-18	0-18	0-18
	19-39	19-39	19-39
	40-65	40-65	40-65
	66+	66+	66+

IV. ELOPEMENT

1. Does your facility have a locked unit(s) for residents prone to wandering? ☐ Yes ☐ No
   If No, please explain: _____
2. What system is in use for residents prone to wandering? _____
3. Are all exit doors at all locations alarmed? ☐ Yes ☐ No
   If No, please explain: _____
4. How many residents have eloped from your facility in the last three years? _____
   If any, please provide details: _____
5. What is the protocol or criteria for placing an alarm bracelet on a resident? _____
6. Is the family notified of the placement of an alarm bracelet on a resident? ☐ Yes ☐ No

V. BEDSORE INFORMATION

Reporting Date: ____/____/____

1. Please indicate number of bedsores:

Bedsores	Stage II	Stage III	Stage IV
Acquired in Facility:			
Inherited from Another Location:			

2. Please provide a description of the protocols/procedures in place for treating bedsores: _____

VI. MEDICATION ADMINISTRATION/FOOD CONTROLS

1 Is the unit dose medication system used by your facility? ☐ Yes ☐ No
   If No, what system is used? _____
2. Indicate who is responsible for administering medications to the residents in your facility:
   ☐ Licensed Staff ☐ Medication Aide
3. Are medications kept under locked conditions? ☐ Yes ☐ No
   If No, please explain: _____
4. What controls/standards are in place to handle any special dietary needs of the residents? _____

VII. PREMISES INFORMATION (If more than three locations, please use separate page.)

	Location 1	Location 2	Location 3
Type of construction:			
Owned or leased:			
Year built/updated:			
Square feet:			
Number of floors:			
If multi-story building, on which floor are non-ambulatory/ Alzheimer's residents located?			
Are there smoke detectors in all bedrooms/hallways?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes:	☐ Hardwired ☐ Battery	☐ Hardwired ☐ Battery	☐ Hardwired ☐ Battery
Fire alarm:	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None
Is the building fully sprinklered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If No, what % is sprinklered?	%	%	%

VIII. STAFF

1. Indicate for each category:

	# of Years in Position at Facility	# of Years of Experience in Position
Administrator (attach resume)		
Director of Nursing		
Medical Director		

2. Please indicate number of current staff at all locations:

	1st Shift	2nd Shift	3rd Shift	Are all services provided by employees?	If No, what % of services are provided by non-employees?	If No, who provides services?
RNs				☐ Yes ☐ No		
LPNs				☐ Yes ☐ No		
Nurse Aides				☐ Yes ☐ No		
Counselors				☐ Yes ☐ No		
Therapists				☐ Yes ☐ No		

3. Is the medical director employed by you? ☐ Yes ☐ No

IX. LICENSING (please submit a copy of your current license)

1. Are you currently licensed for operations by the proper regulatory authorities? ☐ Yes ☐ No
2. Is the license conditional? ☐ Yes ☐ No
   If Yes, please explain: _____
3. Has the license ever been revoked? ☐ Yes ☐ No
   If Yes, please explain: _____

X. STATE INSPECTION

1. Date of last State Inspection/Survey: _____
2. Total number of Deficiencies: _____

3. Number of Deficiencies (Nursing Homes only): D, E & F: _____ G, H & J: _____
4. Corrective Action Plan accepted by State: ☐ Yes ☐ No
   If Yes, date accepted: ____/____/_____
5. Number of complaints investigated by State the past two years: _____
6. Number of substantiated complaints: _____

Please attach a copy of the following with your submission:

- Most recent state survey
- Current license
- Five years hard copy of current dated loss runs.

NOTICE TO APPLICANT

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

_____

Applicant's Authorized Signature (of Principal, Partner or President) Title Date

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed by a Principal, Partner or President of the Applicant acting as the authorized agent of the person(s) and entity (ies) proposed for this insurance, completed and dated to be considered for quotation.

AGENT OR BROKER INFORMATION

Agency Name	Street Address	City	State	Zip Code

Producer Name	E-mail Address	Telephone #	Fax #

Producer Code (if applicable)	Producer License #	FL Register # (if applicable)	Surplus Lines License #