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 HOME HEALTH CARE MEDICAL STAFFING AGENCY SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

TYPE OF FIRM:

☐ Home Health Care ☐ Medical Equipment Supplier (Complete DME Supplement)
☐ Nurse Registry ☐ Supplemental Staffing ☐ Other

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. Enterprise is: ☐ For Profit ☐ Not For Profit
11. Type of Enterprise: ☐ Corporation ☐ Individual ☐ Partnership ☐ Joint Venture ☐ Municipality
    ☐ Other (describe): _____
12. Indicate estimated gross receipts/operating budget for the next twelve (12) months: _____
13. Indicate estimated payroll for the next twelve (12) months: _____
14. Is Applicant engaged in, owned by, associated with or controlled by any other business? ☐ No ☐ Yes
    If Yes, please explain:
15. Is Applicant licensed in all states in which operating? ☐ No ☐ Yes
    If No, please explain: _____
16. Is Applicant Medicare licensed? ☐ No ☐ Yes
17. Is Applicant Medicaid licensed? ☐ No ☐ Yes
18. Has Applicant's license ever been suspended or revoked? ☐ No ☐ Yes
    If Yes, please explain: _____
19. Does Applicant's hold any certifications? ☐ No ☐ Yes
    If Yes, please list: _____
20. Is Applicant's a member of any association? ☐ No ☐ Yes
    If Yes, please list: _____

II. OPERATIONS

THIS SECTION MUST BE COMPLETED:

1. Description of employees or contracted personnel:

	Number of Employees	Number of Independent Contractors	Do all workers carry their own insurance?	Where are services rendered? % in Hospitals		% in Nursing Homes		% in Private Homes	% in Prisons/ Lockdown
				*S.S.	*P.D.	*S.S.	*P.D.		*S.S.
Aide			☐ No ☐ Yes						
CRNA			☐ No ☐ Yes						
Dental Hygienist			☐ No ☐ Yes						
Dentist			☐ No ☐ Yes						
Lab/X-ray/Ultrasound Tech			☐ No ☐ Yes						
LPN			☐ No ☐ Yes						
Medical Billing/Receptionist			☐ No ☐ Yes						
Medical Technician			☐ No ☐ Yes						
Nurse Practitioner			☐ No ☐ Yes						
Occupational Therapist			☐ No ☐ Yes						
Optometrist			☐ No ☐ Yes						
Pharmacist			☐ No ☐ Yes						
Pharmacy Technician			☐ No ☐ Yes						
Physical Therapist			☐ No ☐ Yes						
Physician Medical Director			☐ No ☐ Yes						
Physicians' Assistant			☐ No ☐ Yes						
Radiology Technician			☐ No ☐ Yes						
Respiratory Therapist			☐ No ☐ Yes						
RN			☐ No ☐ Yes						
Social Worker			☐ No ☐ Yes						
Speech Therapist			☐ No ☐ Yes						
Other (specify):			☐ No ☐ Yes						
Other (specify):			☐ No ☐ Yes						
Other (specify):			☐ No ☐ Yes						

*S.S. = Supplemental Staffing, P.D. = Private Duty

2. Does Applicant want this policy to provide coverage for independent contractors? ☐ No ☐ Yes

3. Schedule of Physicians – on Staff or Contracted:

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

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

_____

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

6. Indicate percentage of patients in the following age ranges (total must equal 100%):

_____ % 0-4 _____ % 5-17 _____ % 18-35 _____ % 36-50 _____ % 51-65 _____ % 65+

7. Indicate percentage of types of services provided (total must equal 100%):

Personal Care Chore or Companion	____%	Respiratory Therapy (Trach care/Ventilator care)	____%
Rehabilitation	____%	Radiation Therapy	____%
Infusion Therapy	____%	Skilled Nursing Care	____%
Hospice	____%	Social Services	____%
Supplemental Staffing	____%	Infant Care	____%
Obstetrical Services	____%	Pediatric Care	____%
Adult Day Care*	____%	Retail Pharmacy	____%
Child Day Care*	____%	Closed Pharmacy	____%
Medical Equipment Supplier	____%	Clinics Owned/Operated	____%
Meals on Wheels	____%	Other Services (please specify)	____%
Skin Care or Bedsore Wound Care	____%		

*Firms providing day care may be required to complete a supplemental application.

8. Check the hiring procedures that apply or are performed by this operation:
   - ☐ Criminal Background Checks
   - ☐ Verification of certification or professional licensing
   - ☐ Drug, alcohol and sexual abuse screening or testing
   - ☐ Reference Checks
   - ☐ Questioning of employees in their previous involvement as defendants in professional malpractice litigation
9. Does Applicant utilize a formal written Quality Assurance & Risk Management Program? ☐ No ☐ Yes
   If No, please explain: _____
10. Is the overall responsibility for Risk Management assigned to one individual in Applicant's firm? ☐ No ☐ Yes
    If Yes, please explain: _____
11. Is an informed consent document placed in the patient's medical record? ☐ No ☐ Yes
12. Does Applicant conduct patient/client surveys? (If Yes, attach sample.) ☐ No ☐ Yes
    If Yes, are the results of patient/client surveys used to improve day to day operations? ☐ No ☐ Yes
13. Are all staff, including contractor and volunteers, required to have the following training:
    - Drug administration procedures: ☐ No ☐ Yes
    - Medical emergencies: ☐ No ☐ Yes
    - Daily work reports: ☐ No ☐ Yes
    - Service discontinuation: ☐ No ☐ Yes
    - Safe lifting, transferring and ambulating: ☐ No ☐ Yes
    - Incident reporting: ☐ No ☐ Yes
    - Sexual/physical abuse awareness training: ☐ No ☐ Yes
    - Medical equipment training: ☐ No ☐ Yes
    - Patient rights: ☐ No ☐ Yes

    If No, please explain: _____

III. SUPPLEMENTAL STAFFING

1. Does Applicant provide temporary workers to other businesses or institutions? ☐ No ☐ Yes
2. Does Applicant acknowledge that the Colony Insurance policy does not cover liability Applicant assumes in any contract or agreement? ☐ No ☐ Yes
3. Do contracts Applicant signs make Applicant company liable for negligent acts of those temporary workers while they are working in and being supervised by those other businesses or institutions? ☐ No ☐ Yes

4. Does Applicant staff any hospitals? ☐ No ☐ Yes

   If Yes, does Applicant staff any Labor & Delivery, Emergency Room or Surgery positions? ☐ No ☐ Yes

   If Yes, estimated annual revenue from these placements: **$** _____

5. Does Applicant staff any correctional facilities? ☐ No ☐ Yes

   If Yes, estimated annual revenue from these placements: **$** _____

IV. CURRENT INSURANCE

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

1. Has Applicant had previous insurance for this enterprise? ☐ No ☐ Yes

   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

V. 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 Applicant's current insurer. Applicant's 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 Applicant or to Applicant's past or Applicant's 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 Applicant's facilities for which coverage is being requested, but where such incidents have not been reported to any insurer.

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   - 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 Applicant's care that have reached Stage IV.

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

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

2. Risk Management Protocols

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

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

Name: _____ Title: _____

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

If Yes, please explain: _____

_____

_____

Please attach a copy of the following with Applicant's 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.