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
# SOCIAL SERVICE ORGANIZATION SUPPLEMENTAL APPLICATION

**SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION**

**Applicant Name:** _____

## OPERATIONS

1. Please indicate number of beds:

| | | | |
|---|---|---|---|
| Mental Health Inpatient: | | Group Home: | |
| Alcohol/Drug Inpatient: | | Shelters: | |
| Alcohol/Drug Detox.: | | Independent Living: | |
| Halfway House: | | Foster Care (children): | |
| Apartments: | | Other (specify): | |

2. a. Are any of the above beds medical or non-medical detoxification beds? ☐ Yes ☐ No

   b. If Yes, please indicate number of beds:

| | |
|---|---|
| Medical: | |
| Non-Medical: | |

3. Please indicate number of annual outpatient or client visits:

| | |
|---|---|
| Mental Health Inpatient: | |
| Alcohol/Drug Inpatient: | |
| Alcohol/Drug Detox.: | |
| Halfway House: | |
| Apartments: | |

4. Please indicate number of annual outpatient or client visits:

| | |
|---|---|
| Alcohol/Drug Rehab: | |
| Counseling: | |
| Mental Health: | |
| Methadone: | |

5. Please indicate number of clients per day:

| | | | |
|---|---|---|---|
| Adult Day Care: | | Partial Hospitalization: | |
| Child Day Care: | | Sheltered Workshops: | |

6. Please indicate number of calls (annually):

| | | | |
|---|---|---|---|
| Hotline: | | Transport - Emergency: | |
| Information: | | Non-Emergency: | |
| Referral: | | Other (specify): | |

7. a. Is transportation provided for clients? ☐ Yes ☐ No

   b. If Yes, please explain: _____

8. Are patients or clients subject to:
   a. Involuntary commitment? ☐ Yes ☐ No
   b. Court order? ☐ Yes ☐ No
   c. Physician's written order? ☐ Yes ☐ No
   d. Consent of parent or guardian? ☐ Yes ☐ No

9. a. Does the facility do any fund raising or special events? ☐ Yes ☐ No

   b. If Yes, please indicate amount of receipts: _____

   c. Describe events or fundraisers: _____

10. a. Does the facility offer off-premises services? ☐ Yes ☐ No

    b. If Yes, please explain: _____

## ABUSE / MOLESTATION EXPOSURES

1. What are the age groups of patients/residents/clients? _____
2. What is the patient to employee ratio? _____
3. a. Are there rules or guidelines prohibiting closed-door one-on-one counseling? ☐ Yes ☐ No

   b. If Yes, please describe: _____
4. Are volunteers subject to the same hiring procedures as employees? ☐ Yes ☐ No
5. Have any employees or volunteers been subjects of an abuse/molestation investigation? ☐ Yes ☐ No

### 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 #