Chris-Leef General Agency, Inc.
P.O. Box 3747 Shawnee Mission, KS. 66203
(913) 631-1232 (913) 631-1128 fax
(800) 548-0491 (800) 383-1235 fax
www.chris-leef.com

ALLIED MEDICAL GENERAL APPLICATION

APPLICANT'S INFORMATION:

DESIRED EFFECTIVE DATE:

APPLICANT NAME:			
MAILING ADDRESS:			
CITY, STATE, ZIP:			
COUNTY:		PHONE NUMBER:	
INSPECTION CONTACT:		DATE ESTABLISHED:	
YEARS IN BUSINESS UNDER CURRENT MGMT:			

Type of Enterprise: ☐ Corporation ☐ Individual ☐ Partnership ☐ Municipality ☐ For Profit
☐ Joint Venture ☐ Other: ______________________________

Estimated receipts/operating budget for the next 12 months:	
Estimated payroll for the next 12 months:	

Type of Operation:

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

Full description of services rendered: ______________________________

____

____

____

Current Insurance:
Has applicant had previous insurance for this enterprise? ☐ No ☐ Yes
If "Yes," complete the following:

General Liability		Professional Liability	
Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	
Retro date if Claims Made		Retro date if Claims Made	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? If "Yes," complete the following (use a separate sheet if necessary):	☐ No ☐ Yes
Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been aware of any circumstances which may result in a claim? ☐ No ☐ Yes

If "Yes," provide full details: ______________________________

____

____

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

Of what professional association(s) is Insured a member in good standing? ______________________________

____

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

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.

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
Do you want the physician to be covered under the Center's policy?					☐ No ☐ Yes
Are any drugs or medications administered or prescribed? If "Yes," please explain:					☐ No ☐ Yes
Is electroshock therapy utilized? If "Yes," how many per year?					☐ No ☐ Yes

Schedule of Location: (if more than three locations, attach a separate sheet of locations)	
#1 Address	
Types of Services Provided	

#2 Address	
Types of Services Provided	
#3 Address	
Types of Services Provided	

Question	Answer
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If "Yes," describe and submit brochure or detailed narrative of activities.	☐ No ☐ Yes
Are there any animal exposures on premises? ☐ Owned? ☐ Non-owned? If "Yes," please explain, including number of animals and type/breed: ______ ______	☐ No ☐ Yes
Are there any swimming or boating activities?	☐ No ☐ Yes
Is pool fenced with a self-locking gate?	☐ No ☐ Yes
Diving board?	☐ No ☐ Yes
Slide?	☐ No ☐ Yes

☐ Residential or Inpatient - **complete supplemental application**
☐ Foster Care or Adoption - **complete supplemental application**

Check the coverages and limits that the applicant would like quoted:				
What coverages:	☐ GL ☐ 100/100 ☐ 1/1	☐ Professional ☐ 300/300 ☐ 1/2	☐ Property (attach acord app) ☐ 500/500 ☐ 1/3	☐ Excess ______ (attach acord app)
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? At what limits:	☐ 25/50 ☐ 250/250	☐ 50/100 ☐ 500/500	☐ 100/300 ☐ Other	

****

Please attach a copy of the following with your submission:

(If Prior Acts coverage is desired) Prior Acts supplement, available on the website: www.colonyins.com
Five years of currently dated loss runs (if in business less than five years, please attach a resume of the owner/director)
Brochure(s) available or other information pertaining to the programs offered

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

______________________ Applicant's Signature

______________________ Sub-Producer

______________________ Title/Date

______________________ Producer

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

ALLIED MEDICAL AMBULANCE/ NON-EMERGENCY TRANSPORT SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Number of volunteer members: ___________ Number of Paid members: ____________
   Population of area served: ________________ Radius of operation (mi.): _____________
2. Is your service involved in: Air Ambulance Operations ☐ No ☐ Yes
   Water Rescue Operations ☐ No ☐ Yes
   Off-shore EMS ☐ No ☐ Yes
   Activities or Operations other than EMS ☐ No ☐ Yes
   Special Event EMS ☐ No ☐ Yes
   If "Yes," to any of the above, provide details: ____
   ____
   ____

Number of:		Number of hours of annual training for each:
EMTS - A		
EMTS - P		
Nurses		
Other		

Number of:		**Number of:**	
EMTS		Non-emergency Calls	
Paramedics		Ambulances	
Emergency Calls		Vans	
		Air Ambulance	

3. Do you administer any anesthesia? ☐ No ☐ Yes
4. Any physician, nurse practitioner or CRNA exposure? ☐ No ☐ Yes
   Please provide number_____ and explain duties: ____
5. Do you contract your services to others on an independent contractor basis? ☐ No ☐ Yes
6. If "Yes," please advise to whom you contract your work: ________________________________
7. Name of your Auto Liability Insurance Carrier for the upcoming policy year? ____________________
   ____
   a. Does your Auto Liability policy specifically exclude claims arising from loading and unloading of patients? ☐ No ☐ Yes
   b. Does your Auto Liability policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients? ☐ No ☐ Yes
   c. if "No," please explain: ____
   ____

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