Chris-Leef General Agency, Inc.

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(913) 631-1232 (913) 631-1128 fax
(800) 548-0491 (800) 383-1235 fax
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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: ______________________________

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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.

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted	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					☐ 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	

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	☐ Professional	☐ Property (attach acord app)	☐ Excess ___________ (attach acord app)
	☐ 100/100	☐ 300/300	☐ 500/500	
	☐ 1/1	☐ 1/2	☐ 1/3	
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees?				
At what limits:	☐ 25/50	☐ 50/100	☐ 100/300	
	☐ 250/250	☐ 500/500	☐ Other	

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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 GROUP HOME (NON-ELDERLY RESIDENTS)
SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

For NURSING HOMES, please see the Allied Medical Asst Living facility (Elderly Residents) application,

APPLICANT NAME:	
LOCATION NUMBER:	
LOCATION ADDRESS:	

Number of licensed beds		Number of occupied beds	
Range of client ages?	How many male?	How many female?	
Patient Census	**# Ambulatory**	**# Non-Ambulatorv**	
Severely/Profoundly Retarded			
Mild/Moderately Retarded			
Psychotic or Sociopathic			
Schizophrenic			
Drug or alcohol rehab			
Emotionally disturbed/depressed			
Other (specify)			
What precautions are taken to keep track of patients?			
Sign out procedures?			☐ No ☐ Yes
Alarms on doors to prevent clients from wandering from the residence?			☐ No ☐ Yes
Is the insured a,	☐ Building Owner	☐ Tenant	☐ General Lessee
Construction of building:		Square feet:	
Year built/updated		Number of floors	
Age of wiring/update		Number of fire extinguishers	
Number of fire escapes		Is the building sprinklered?	☐ No ☐ Yes
Do all bedrooms/hallways have smoke detectors?	☐ No ☐ Yes	Electronic or Battery operated detectors?	
Local fire alarm?	☐ No ☐ Yes	Central station fire alarm?	☐ No ☐ Yes
Are handrails provided in hallways and bathrooms?	☐ No ☐ Yes	Distance to the nearest fire station	

# of Staff	1st Shift	2nd Shift	3rd Shift	Staff	1st Shift	2nd Shift	3rd Shift
MD				General Caregiver			
RN				Psychiatrists			
LPN				Counselor			
Nurse Aids				Speech Therapists:			
				Physical Therapists:			
Psychologists				Other (specify)			

Are Psy/MD:	☐ employees or	☐ Independent Contractors	
Do any residents attend school/workshops?	☐	☐ Yes-number: ____________	
Do any residents work full or part time?	☐	☐ Yes-number: ____________	

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Please attach complete details about 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 ______________________

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