

Chris-Leef General Agency, Inc.
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(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:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: _____														
Estimated receipts/operating budget for the next 12 months:															
Estimated payroll for the next 12 months:															
Type of Operation:	<table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"><input type="checkbox"/> Mental Health Inpatient</td> <td style="width:50%; border:none;"><input type="checkbox"/> Group Home (Elderly)</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Shelters</td> <td style="border:none;"><input type="checkbox"/> Group Home (Non-Elderly)</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Alcohol/Drug Inpatient</td> <td style="border:none;"><input type="checkbox"/> Foster Care (children)</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Alcohol/Drug Detox.</td> <td style="border:none;"><input type="checkbox"/> Independent Living (Elderly)</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Halfway House</td> <td style="border:none;"><input type="checkbox"/> Independent Living (Non-Elderly)</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Apartments</td> <td style="border:none;"><input type="checkbox"/> Other (specify)</td> </tr> </table>			<input type="checkbox"/> Mental Health Inpatient	<input type="checkbox"/> Group Home (Elderly)	<input type="checkbox"/> Shelters	<input type="checkbox"/> Group Home (Non-Elderly)	<input type="checkbox"/> Alcohol/Drug Inpatient	<input type="checkbox"/> Foster Care (children)	<input type="checkbox"/> Alcohol/Drug Detox.	<input type="checkbox"/> Independent Living (Elderly)	<input type="checkbox"/> Halfway House	<input type="checkbox"/> Independent Living (Non-Elderly)	<input type="checkbox"/> Apartments	<input type="checkbox"/> Other (specify)
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Full description of services rendered:	_____ _____ _____ _____														

Current Insurance:			
Has applicant had previous insurance for this enterprise?			<input type="checkbox"/> No <input type="checkbox"/> 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
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you want the physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If "Yes," please explain:					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If "Yes," how many per year?					<input type="checkbox"/> No <input type="checkbox"/> 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.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?	<input type="checkbox"/> No <input type="checkbox"/> Yes

<input type="checkbox"/> Residential or Inpatient - complete supplemental application
<input type="checkbox"/> Foster Care or Adoption - complete supplemental application

Check the coverages and limits that the applicant would like quoted:				
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)	<input type="checkbox"/> Excess _____
	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500	(attach acord app)
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/3	
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees?				
At what limits:	<input type="checkbox"/> 25/50	<input type="checkbox"/> 50/100	<input type="checkbox"/> 100/300	
	<input type="checkbox"/> 250/250	<input type="checkbox"/> 500/500	<input type="checkbox"/> 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 DURABLE MEDICAL EQUIPMENT SUPPLEMENTAL APPLICATION
SUBMIT WITH COLONY GENERAL LIABILITY APPLICATION

GENERAL INFORMATION:

1. Percentage of sales to the public: ____% Percentage of sales to institutions: ____%
2. Expendable Items: Intended for one time usage (i.e. adhesive tape, bandages, or hypodermic needles, etc.)
Estimated receipts in the next 12 months: \$ _____
Actual receipts in the last 12 months: \$ _____
Any pharmaceutical product/solutions sales? No Yes
If "Yes," what percentage of the above est. receipts will be pharmaceuticals? _____%
3. Non-expendable Items: Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.
Estimated receipts in the next 12 months: \$ _____
Actual receipts in the last 12 months: \$ _____
Any lease or rental of the above equipment? No Yes
If "Yes," lease/rental of equipment equals: _____% of the above estimated receipts
4. Diagnostic or Treatment Devices: This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.
Estimated receipts in the next 12 months: \$ _____
Actual receipts in the last 12 months: \$ _____
Any lease or rental of the above equipment? No Yes
If "Yes," lease/rental of equipment equals: _____% of the above estimated receipts
5. Life Sustaining or Critical Life Monitoring Equipment or Devices: This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction /failure or improper function of which could result in death or serious deterioration in health condition.
Estimated receipts in the next 12 months: \$ _____
Actual receipts in the last 12 months: \$ _____
Any lease or rental of the above equipment? No Yes
If "Yes," lease/rental of equipment equals: _____% of the above estimated receipts
6. Have any of the products that you distribute ever been recalled? No Yes
If "Yes," please explain: _____
7. Is the applicant named as an Additional Insured-Vendor on the manufacturer's policy for:
 ALL products SOME products NO products
If for SOME products, list those products and the Annual Receipts for each: _____
-

8. Are written instructions for the use of the products provided to the user?
If "Yes," are the written instructions reviewed with and required to be signed off by the user? No Yes
9. Do you modify any products in any way after their original manufacture?
If "Yes," please explain: _____ No Yes
10. Do you repackage or relabel any items obtained from suppliers?
If "Yes," please explain: _____ No Yes
11. Is any equipment sold with the applicant's label?
If "Yes," please explain: _____ No Yes
12. Do you maintain a written quality control program? No Yes
13. Do you have your own sales staff?
If "Yes," are they trained by the manufacturer? No Yes
14. Are all devices and/or equipment checked and their condition documented prior to their release? No Yes
15. Is preventive maintenance performed on all equipment & devices according to a written schedule? No Yes
16. Do you repair or sell other people's used equipment? No Yes
17. Are serial numbers of the finished product shown on shipment invoices and complete records kept of inventory shipments? No Yes
18. Do you use the services of an EPA approved contractor to dispose hazardous waste materials? No Yes
19. Are any products flammable or explosive?
If "Yes," please explain: _____ No Yes
20. Does applicant have any exposure to nuclear or radioactive materials?
If "Yes," please explain: _____ No Yes
21. For life sustaining or critical life monitoring devices or equipment, describe the 24 hour service, 365 day/year program that exists: _____
22. Do you distribute oxygen cylinders?
Are they pre-filled or do you fill them at your premises? _____ No Yes
23. Do you follow F.D.A. and D.O.T. regulations for the sterilization and transportation of oxygen? No Yes

MAINTENANCE AND/OR REPAIR OF EQUIPMENT--- LEASED OR SOLD:

24. Do you subcontract labor for installation, service or repair of any products? No Yes
If "Yes," describe what equipment this applies to: _____
Please describe which types of equipment YOU perform maintenance or repairs on: _____
25. Are manufacturer recommendations followed for all maintenance and repair of equipment? No Yes
If "No," please explain: _____
26. Are certificates of insurance obtained from those entities that proved the maintenance and repair Services? No Yes

MAINTENANCE AND/OR REPAIR OF EQUIPMENT--- LEASED OR SOLD (continued):

27. What limits of liability do you require of these maintenance and/or repair subcontractors? _____

Additional Comments or Interests: _____

Please attach a brochure and/or list of equipment and supplies handled.

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

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