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

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	

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.

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ALLIED MEDICAL SCHOOL QUESTIONAIRE SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION

1. Number of students age: _____0-5 _____6-12 _____13-18 _____19+
2. Number of teachers: _____
3. Number and type of medical staff: _____
4. Is school accredited? ☐ No ☐ Yes
   If "Yes," by whom? _____
5. Are teachers certified by the state? ☐ No ☐ Yes
6. Is the school: ☐ public ☐ private
7. When was the school established? _____
8. Does the school include dorms for student housing? ☐ No ☐ Yes
9. Does the school have a volunteer nurse? ☐ No ☐ Yes
10. What days and hours is the school in operation? _____
11. Does the school provide transportation for any students? ☐ No ☐ Yes
    If "Yes," does school own vehicles for transportation?
12. Please explain elopement controls: _____
13. Does the school provide driver's education training? ☐ No ☐ Yes
14. Is corporal punishment allowed? ☐ No ☐ Yes
15. Does school have any stadiums or bleachers? ☐ No ☐ Yes
16. What type of entry alarms are in place? ☐ None ☐ local ☐ central station ☐ other: _____
17. Please check any of the following activities offered:
    - ☐ Archery
    - ☐ Baseball
    - ☐ Basketball
    - ☐ Boxing
    - ☐ Climbing wall
    - ☐ Equine/horseback riding school
    - ☐ Flag Football
    - ☐ Wrestling
    - ☐ Gymnastics
    - ☐ Martial Arts-contact
    - ☐ Martial Arts-n on -contact
    - ☐ Riflery
    - ☐ Swimming or Diving (complete Pool Questionaire if there is a pool on premises)
    - ☐ Tackle football
    - ☐ Others: _____
18. Are any activities unsupervised? ☐ No ☐ Yes

ACCIDENT INSURANCE

19. Are all students covered by the accident insurance even if not participating on a team or sport? If "Yes," provide carrier name, policy number, policy period, and limits: ☐ No ☐ Yes

20. Are all team sports members covered by accident insurance? ☐ No ☐ Yes
21. Is the purchase of accident insurance optional at the participants' expense? ☐ No ☐ Yes

SPECIAL EDUCATION

22. If special education was indicated above, please answer the following questions:
What type of students are enrolled:
- ☐ physically handicapped
- ☐ developmentally disabled
- ☐ emotionally disturbed
- ☐ violent
- ☐ mentally disturbed
- ☐ suicidal
- ☐ other: _____

23. Do you have facilities in place for restraint of students?
If "Yes," provide details of restraint guidelines as an attachment.

****

Please attach copies of all contractual agreements including those involved in off-premises training.

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

_____
Agent:

_____
Title/Date

_____
Agent Phone:

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.

Submit