ALLIED MEDICAL EXERCISE & HEALTH STUDIOS SUPPLEMENTAL APPLICATION

SUBMIT WITH ACORD APPLICATION

APPLICANT'S INFORMATION: DESIRED EFFECTIVE DATE:

APPLICANT NAME:			
BUSINESS NAME:			
INSPECTION CONTACT:		PHONE:	
MAILING ADDRESS:			
CITY, STATE, ZIP:			
INSURED ADDRESS:	☐ Same as above		
TYPE OF ENTERPRISE:	☐ Corporation ☐ Individual ☐ Partnership ☐ Municipality ☐ For Profit ☐ Joint Venture ☐ Other: _____		

GENERAL INFORMATION:

1. Is applicant engaged in, owned by, associated with or involved in any other enterprise? ☐ No ☐ Yes
   If "Yes," provide details:_____
2. Date established: _____/_____/_____
3. Provide details of licensing or certification needed for this operation:_____
4. State the number of the following personnel:
   _____Partners/owners _____Full Time Staff _____Part Time Staff
   _____Independent Contractors _____Professional Trainers _____Other (specify):_____
5. How many Tanning Beds?_____
   Are signs posted prohibiting the use of beds during pregnancy or if on medication? ☐ No ☐ Yes
   Are goggles provided? ☐ No ☐ Yes
   Are beds manufactured in the Unites States? ☐ No ☐ Yes
   Self-timers? ☐ No ☐ Yes
   Are beds UL approved? ☐ No ☐ Yes
   Have all employees received training in the use of timers? ☐ No ☐ Yes
6. Is there a pool on the premises? ☐ No ☐ Yes
   Are rules posted? ☐ No ☐ Yes
   Lifeguard on duty? ☐ No ☐ Yes
   If "Yes," is diving board at the deepest end of the pool? ☐ No ☐ Yes
   What is the depth at the deepest end?_____ Are there depth markers? ☐ No ☐ Yes

7. Check any of the following facilities or activities that are available:

☐ Aerobics ☐ Trampolines ☐ Nutritional Counseling
☐ Gymnastics ☐ Electrode Machines ☐ Weight Machines/Free Weights
☐ Body Wraps ☐ Stress Testing ☐ Blood Analysis
☐ Karate ☐ Climbing Wall ☐ Weight Loss/Diet Centers ☐ Protein diet plans

8. Any shower facilities? ☐ No ☐ Yes
   If "Yes," do they have non-skid floors? ☐ No ☐ Yes
   a. Sauna or Steam facilities? ☐ No ☐ Yes
   b. Jacuzzi? ☐ No ☐ Yes

9. Number of Tennis Courts? _____
   Number of Racquetball/Handball courts? _____

10. Are child care facilities provided? ☐ No ☐ Yes
    If "Yes," maximum number of children at one time: _____
    a. Age of youngest child you will accept: _____
    b. Number of child care attendants: _____

11. Pro shop on premises? ☐ No ☐ Yes
    If "Yes," gross sales: _____
    a. Do you sell any diet/nutritional supplements? ☐ No ☐ Yes
    If "Yes," please explain: _____
    b. Are any products manufactured under your specifications or sold under your label? ☐ No ☐ Yes
    If "Yes," please explain: _____

12. Snack bar/Restaurant on premises? ☐ No ☐ Yes
    If "Yes," gross sales: _____

13. Total number of members: _____
    Average age of members: _____

14. Are medical examinations required for new members? ☐ No ☐ Yes

15. What is your procedure for handling accidents or injuries? _____

_____

16. Does your staff have training in CPR and First Aid? ☐ No ☐ Yes

17. Hours of operations: Day(s) of the Week: _____ From: _____ To: _____
    Day(s) of the Week: _____ From: _____ To: _____
    Day(s) of the Week: _____ From: _____ To: _____

18. Annual Gross Receipts: Next 12 months: _____
    Last 12 months: _____

19. Has applicant had previous insurance for this enterprise? ☐ No ☐ Yes
    If "Yes," complete the following:
    Insurance company: _____
    Policy Period: _____ to _____
    Limits of Liability: _____
    Premium: _____
    Type of coverage: ☐ Occurrence ☐ Claims Made
    Current General Liability Carrier: _____
    Limits requested: ☐ 100/100 ☐ 300/300 ☐ 500/500 ☐ 1/1 ☐ 1/2 ☐ 1/3

20. During the past five years, have any claims been presented to your current or prior insurance carrier or to you? ☐ No ☐ Yes
    If "Yes," provide full details (include description of claim, amounts paid, and reserves): _____

_____

21. Is applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? ☐ No ☐ Yes
If "Yes," provide full details: _____

22. Has applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, policy canceled, or non-renewed in the past five years? ☐ No ☐ Yes
If "Yes," provide full details: _____

23. Additional Comments and Interests: _____

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

* 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

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 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 ☐ In-Patient -Psychiatric ☐ 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)	☐ Prison
☐ Shelters	☐ Group Home (Non-Elderly)	☐ Jail
☐ Alcohol/Drug Inpatient	☐ Foster Care (children)	☐ Boot Camp
☐ 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	

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 lakes, ponds, rivers or other bodies of water on the premises? If "Yes," please explain:_____	☐ 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 _____ ☐ 100/100 ☐ 300/300 ☐ 500/500 (attach acord app) ☐ 1/1 ☐ ½ ☐ 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 _____	

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.

* 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