SOCIAL SERVICE ORGANIZATION APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

Applicant Name:_____
Location Number:_____
Location Address:_____

Provide five years of General Liability insurance coverage information below:				
Policy Term	**Company**	**Limits**	**Occurrence or Claims-made**	**Retroactive Date**
04/05				
03/04				
02/03				
01/02				
00/01				

Provide five years of Professional Liability insurance coverage information below:				
Policy Term	**Company**	**Limits**	**Occurrence or Claims-made**	**Retroactive Date**
04/05				
03/04				
02/03				
01/02				
00/01				

1. 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: ☐ No ☐ Yes
   a. Date of loss:_____
   b. Current reserve or amount paid:_____
   c. Description of loss:_____

   a. Date of loss:_____
   b. Current reserve or amount paid:_____
   c. Description of loss:_____

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

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

4. Of what professional association(s) is Insured a member in good standing?_____

_____

5. Please fill out the following information with the appropriate number:

Staff	Full Time	Part Time	Contracted/ Employed
Administrators			
MD/Physicians			
Nurse Practitioner			
Nurses – LPN or RN			
Homemakers/Nurse Aids			
Pharmacist			
Psychologists			
Psychiatrist			
Counselors			
Respiratory Therapist			
Physical Therapists			
Speech & Hearing Therapist			
Social Workers			
Students or volunteers			
Other (specify)			

6. Check the hiring procedures that apply or are performed by this operation:
   - ☐ Criminal Background Checks
   - ☐ Reference Checks
   - ☐ Questioning of employees in their previous involvement as defendants in professional malpractice litigation.
   - ☐ Verification of certification or professional licensing.
   - ☐ Drug, alcohol and sexual abuse screening or testing.

7. Schedule of Physicians – on Staff or Contracted

Name & Specialty	Board Certified	Board Eligible	Hours/ Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance Yes or No

8. Would you like the physician to be covered under the Center's policy? ☐ No ☐ Yes

9. Are any drugs or medications administered or prescribed? ☐ No ☐ Yes
   By whom?_____
   If "Yes," explain:_____

10. Is electroshock therapy utilized? ☐ No ☐ Yes
    If "Yes," how many per year?_____

11. Schedule of Locations: If there are more than 3 locations, attached a separate sheet of locations.

#1 Address	
Type of Services Provided	
#2 Address	
Type of Services Provided	
#3 Address	
Type of Services Provided	

12. Please Indicate the Number of Beds:

Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Detox.		Independent Living	
Halfway House		Foster Care (children)	
Apartments		Psychiatric hospital	
Other (specify):			

13. Are any of the above beds medical or non-medical detoxification beds? ☐ No ☐ Yes
    If "Yes," How many medical:_____ Non-medical:_____

14. Please complete a supplemental app if any of these exposures exist and check any box that applies:
    ☐ **Adult Day Care – Complete Supplemental**
    ☐ **Residential or Inpatient - Complete Group Home Supplemental**
    ☐ **Foster Care or Adoption – Complete Supplemental**

15. Please indicate the Number of annual Outpatient or Client Visits:
    a. Alcohol/Drug Rehab_____
    b. Counseling_____
    c. Mental Health_____
    d. Methadone_____

16. Please indicate the Number of Clients Per Day:
    a. Adult Day Care_____
    b. Partial Hospitalization_____
    c. Child Day Care_____
    d. Sheltered Workshops_____

17. Please indicate the Number of calls (annually):
    a. Hotline_____
    b. Information_____
    c. Transport – Emergency_____
    d. Non-emergency_____
    e. Referral_____
    f. Other:(_____)_____

18. Are there any pools on the premises? ☐ No ☐ Yes
    If "Yes," please answer the following:
    a. How many pools are there?_____
    b. Are pools used exclusively for clients? ☐ No ☐ Yes
    c. Are Clients supervised? ☐ No ☐ Yes
    d. How is pool secured when not in use?_____

19. Is transportation provided for clients? ☐ No ☐ Yes
    Explain:_____

20. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? ☐ No ☐ Yes
    If "Yes," describe and submit brochure or detailed narrative of activities.

21. Is a complete medical history of each patient required prior to admission? ☐ No ☐ Yes

22. Are patients or clients subject to:
    a. Involuntary commitment? ☐ No ☐ Yes
    b. Court Order? ☐ No ☐ Yes
    c. Physician's Written Order? ☐ No ☐ Yes
    d. Consent of parent or Guardian? ☐ No ☐ Yes

23. Does the facility do any fund raising or special events? ☐ No ☐ Yes
    a. Amount of Receipts_____
    b. Describe events or fundraisers:_____

24. Does the facility offer off-premises services? ☐ No ☐ Yes
    If "Yes," please explain:_____

ABUSE / MOLESTATION EXPOSURES

25. What are the age groups of patients/residents/clients?_____

26. What is the patient to employee ratio?_____

27. Are there rules or guidelines prohibiting closed-door one-on-one counseling? ☐ No ☐ Yes
    If "Yes," please describe:_____

28. Are there written compliant procedures and are they displayed prominently? ☐ No ☐ Yes
    If "Yes," please describe:_____

29. Do you have a formal hiring procedure? ☐ No ☐ Yes

30. Do volunteers work directly with patients? ☐ No ☐ Yes

31. Are all prospective employees checked with the Child Abuse Register and with law enforcement agencies for criminal records? ☐ No ☐ Yes

32. Have any employees been subjects of an abuse/molestation investigation? ☐ No ☐ Yes

33. Check the coverage's and limits that the applicant would like quoted:
    What coverage's: ☐ GL ☐ Professional ☐ Property (attach accord app)
    Limits requested: ☐ 100/100 ☐ 300/300 ☐ 500/500
    ☐ 1/1 ☐ 1/2 ☐ 1/3

34. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? ☐ No ☐ Yes
    At what limits: ☐ 25/50 ☐ 50/100 ☐ 100/300
    ☐ 250/250 ☐ 500/500 ☐ Other_____

Higher Abuse limits may be available for select risks.

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.

* 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

_____ _____

Applicant's Signature Sub-Producer

_____ _____

Title/Date Producer

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