

ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Desired Effective Date: _____
2. Applicant Name: _____
3. Mailing Address: _____
4. City, State, Zip: _____
5. County: _____ 6. Telephone Number: _____
7. Inspection Contact: _____ 8. Website Address: _____
9. Date Established: _____ 10. Years in Business Under Current Management: _____
11. Type of Enterprise: Corporation Individual Partnership Joint Venture
 Municipality In-Patient -Psychiatric
 Other (describe): _____
12. Enterprise is: For Profit Not For Profit
13. Estimated receipts/operating budget for the next twelve (12) months: _____
14. Estimated payroll for the next twelve (12) months: _____
15. Type of Operation: Mental Health Inpatient Group Home (Non-Elderly)
 Prison/Jail Boot Camp Lock-down Facility Shelters/Halfway House
 Alcohol/Drug Detox. Alcohol/Drug Inpatient Apartments Foster Care (children)
 Independent Living (Elderly) Assisted Living Facility
 Other (describe): _____
16. Full description of services rendered: _____

II. CURRENT INSURANCE

This section must be completed for prior acts consideration. Attach a copy of expiring policy declarations page.

1. Has Applicant had previous insurance for this enterprise? Yes No

If Yes, complete the following for prior three (3) years of general/professional liability coverage:

Name of Carrier	Effective Date	Expiration Date	Limit	Deductible	Premium	Claims Made (CM) or Occurrence?	CM Retroactive Date

III. CLAIMS ACTIVITY AND PROCEDURES

Important Notice: All known claims and/or potential claim circumstances that could result in a claim are specifically excluded from coverage. Report all such claims and/or circumstances to your current insurer. Failure to disclose such claim, act, or circumstance may result in the proposed insurance being void and/or subject to rescission.

1. After inquiry of all Applicants' personnel, is there any known circumstance, situation, act, error or omission which could reasonably be expected to result in any claim being made against the Applicant? Yes No
2. Are procedures in place that require the documentation of accidents with a written report? Yes No
3. Please indicate total number of incidents recorded from retroactive date on existing policy until today's date? _____
4. How many of these incidents have NOT been reported to any insurance carrier? _____
5. Are you or any of your officers, managers, partners or directors aware of any incidents or accidents which may give rise to a claim for which no incident report has been completed? Yes No
If "Yes", how many such undocumented incidents or accidents have there been from retroactive date on existing policy until today's date? _____
6. On a separate sheet of paper please describe each undocumented accident including a description of the accident, date, types of injuries, etc.
7. Has any license or accreditation ever been suspended, denied or revoked? Yes No
8. Of what professional association(s) is Applicant a member in good standing? _____

9. 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 (attach a separate sheet if necessary): Yes No

Date of Loss	Current Reserve or Amount Paid	Description of Loss

IV. OPERATIONS

1. Indicate current staffing levels:

Staff	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
Administrators				
MD/Physicians				
Nurses				
Homemakers/Nurse Aids				
Psychologists				
Counselors				
Therapists				
Students or volunteers				
Other (describe): _____				

2. 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

3. **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"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Do you want any listed physician to be covered under the facility's policy? Yes No
5. Are any drugs or medications administered or prescribed? Yes No
- If Yes, please explain: _____
6. List the duties of the physician(s) above: _____

V. LOCATION INFORMATION

1. **Schedule of Locations:** If more than five locations, please attach a separate sheet of locations.

	Address	Types of Services Provided
# 1		
# 2		
# 3		
# 4		
# 5		

2. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? Yes No
- If Yes, please submit brochure or describe activities: _____
3. Are there any firearms on the premises? Yes No
- If Yes, please describe: _____
- Are the firearms locked in a secure place away from the residents? Yes No
- If No, please describe: _____
4. Are there any animal exposures on the premises? Yes No
- If Yes, are the animal exposures: Owned? Non-owned?
- If Yes, please describe, including number of animals and type/breed: _____

5. a. Are there any lakes, ponds, rivers, pools or other bodies of water on the premises? Yes No
 If Yes, please describe: _____
- b. Are there any swimming or boating activities? Yes No
- c. If there is a pool or body of water, then is it fenced with a self-locking gate? Yes No
- d. If there is a pool or body of water, then is there a diving board and/or slide? Yes No

VI. COVERAGE REQUESTED

1. Complete and attach the appropriate supplemental application with your submission.
2. Check the coverages and limits that the Applicant would like quoted:
 Coverages: GL Professional Excess (Attach Acord App)
 Limits: \$100,000/\$100,000 \$300,000/\$300,000 \$500,000/\$500,000
 \$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000
3. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? Yes No
 If Yes, at what limits? \$25,000/\$50,000 \$50,000/\$100,000 \$100,000/\$300,000
 \$250,000/\$250,000 \$500,000/\$500,000 Other: _____

Please attach a copy of the following with your submission:

- Five (5) years of currently dated loss runs (if in business less than five (5) years, please attach a resume of the owner/director)
- Brochure(s) available or other information pertaining to the programs offered

* 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.

 Authorized Signature on behalf of Applicant

 Sub-Producer

 Title/Date

 Producer

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.



**ALLIED MEDICAL AMBULANCE/NON-EMERGENCY TRANSPORT
SUPPLEMENTAL APPLICATION**

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Number of volunteer members: _____ Number of Paid members: _____
 Population of area served: _____ Radius of operation (mi.): _____
2. Is your service involved in: Air Ambulance Operations No Yes
 Water Rescue Operations No Yes
 Off-shore EMS No Yes
 Activities or Operations other than EMS No Yes
 Special Event EMS No Yes

If "Yes," to any of the above, provide details: _____

Number of:		Number of hours of annual training for each:
EMTS – A		
EMTS – P		
Nurses		
Other		

Number of:		Number of:	
EMTS		Non-emergency Calls	
Paramedics		Ambulances	
Emergency Calls		Vans	
		Air Ambulance	

3. Do you administer any anesthesia? No Yes
4. Any physician, nurse practitioner or CRNA exposure? No Yes
 Please provide number _____ and explain duties: _____
5. Do you contract your services to others on an independent contractor basis? No Yes
6. If "Yes," please advise to whom you contract your work: _____
7. Name of your Auto Liability Insurance Carrier for the upcoming policy year? _____
- a. Does your Auto Liability policy specifically exclude claims arising from loading and unloading of patients? No Yes
- b. Does your Auto Liability policy remain silent on the applicability of coverage for claims arising from loading and unloading of patients? No Yes
- c. If "No," please explain: _____

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Applicant's Signature

Sub-Producer

Title/Date

Producer

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