Colony Insurance Company
Colony National Insurance Company
Colony Specialty Insurance Company

Allied Medical Risk Summary

From: **Agency:**

Account name:

Street Address:

City, State, Zip:

Proposed effective date:

Date quote needed:

Narrative description of applicant's services (include Gross Receipts, Payroll, & number of beds):

Loss history for the last 5 years (include details of losses xs $25,000):

Current insurance carrier, policy limits, deductible, premium and retrodate (if claims made):

Is the incumbent offering renewal? If so, provide their premium, terms and conditions:

Provide the names of other markets that are receiving a submission and any information on other current quotes.

Desired coverage, target pricing, terms & conditions:

Comments:

Allied Medical New Business Checklist

All Allied Medical Risks

- Colony Allied Medical General Application
- Appropriate Colony Supplement Application
- Submission Cover letter
- Brochures or web-site addresses
- 5 Year current and valued loss runs
- Advise if current carrier is renewing
- Target premium
- Narrative of operation

Residential Facilities to **also** include the following

- Copy of Current License
- Copy of Current State Inspection
- 5 Year current and valued loss runs
- Copy of Resident agreement
- Copy of Insured's Resume/or work experience

1/23/2004

ALLIED MEDICAL HOME HEATH CARE MEDICAL STAFFING AGENCY
SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

TYPE OF FIRM:

☐ Home Health Care ☐ Medical Equipment Supplier (Complete DME Supplement)
☐ Nurse Registry ☐ Supplemental Staffing ☐ Other

GENERAL INFORMATION:

1. Number of independent contractors:_____

   Cost of independent contractors: $_____

2. Do you require and keep certificates of insurance for all independent contractors? ☐ No ☐ Yes

3. Does the applicant utilize a formal written Quality Assurance & Risk Management Program? ☐ No ☐ Yes
   If "No," explain:_____

4. Is the overall responsibility for Risk Management assigned to one individual in your firm? ☐ No ☐ Yes
   If "Yes," explain:_____

5. Is an informed consent document placed in the patient's medical record? ☐ No ☐ Yes
   Does the applicant conduct patient/client surveys? **(If "Yes," attach sample)** ☐ No ☐ Yes
   Are the results of patient/client surveys used to improve day to day operations? ☐ No ☐ Yes

THIS SECTION MUST BE COMPLETED:

6. Description of employees or contracted personnel:

	Number of Employees	Number of Independent Contractors	Do All Workers Carry Their Own Insurance	Where are services rendered? % in Hospitals		% in Nursing Homes		% in Private Homes
				*S.S.	*P.D.	S.S.	P.D.	
Aids			☐ No ☐ Yes					
LPN's			☐ No ☐ Yes					
RN's			☐ No ☐ Yes					
Nurse Practitioner			☐ No ☐ Yes					
Physical Therapist			☐ No ☐ Yes					
Respiratory Therapist			☐ No ☐ Yes					
Speech Therapist			☐ No ☐ Yes					
Occupational Therapist			☐ No ☐ Yes					
Social Worker			☐ No ☐ Yes					
Pharmacist			☐ No ☐ Yes					
Special Training			☐ No ☐ Yes					
Physicians' Assistants			☐ No ☐ Yes					
CRNA's			☐ No ☐ Yes					
Other (specify):			☐ No ☐ Yes					

*S.S. = Supplemetal Staffing, P.D. = Private Duty

7. Give percentage of patients in the following age ranges: _____% 0-4 _____% 5-17
_____% 18-35 _____% 36-50 _____% 51-65 _____% 65+

8. Indicate percentage of revenue derived from IV Therapy: _____%

Percentage of Types of Services Provided (total must equal 100%)

Personal Care Chore or Ccompanion	_____%	Respiratory Therapy (trach care?/ventilator care?)	_____%
Rehabilitation	_____%	Radiation Therapy	_____%
Infusion Therapy	_____%	Skilled Nursing Care	_____%
Hospice	_____%	Social Services	_____%
Supplemental Staffing	_____%	Infant Care	_____%
Obstetrical Services	_____%	Pediatric Care	_____%
Adult Day Care*	_____%	Retail Pharmacy	_____%
Child Day Care*	_____%	Closed Pharmacy	_____%
Medical Equipment Supplier	_____%	Clinics Owned/Operated	_____%
Meals on Wheels	_____%	Other Services (please specify)	_____%
Skin Care or Bedsore Wound Care	_____%		

*Firms providing day care may be required to complete a supplemental application

9. Are employees/contractors references contacted before hired/placed? ☐ No ☐ Yes

How are references checked? _____Written _____Verbal _____Both

If "Verbal only," please explain:_____

Do you perform criminal background checks on prospective employees/contractors? ☐ No ☐ Yes
If "No," please explain:_____

Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation? ☐ No ☐ Yes
If "No," please explain:_____

Is certification and/or professional licensure status of employees & independent contractors verified? ☐ No ☐ Yes

Are employees screened to rule out drug, alcohol and/or sexual abuse? ☐ No ☐ Yes

Are job descriptions provided for all professional and nonprofessional employees? ☐ No ☐ Yes

10. Describe services performed by your LPN's/RN's:_____

_____

11. Do you supply medical equipment or are your personnel responsible for monitoring equipment? ☐ No ☐ Yes
If "Yes," describe all such equipment:_____

12. Do you sell or lease any equipment? ☐ No ☐ Yes
If "Yes," please explain:_____

13. Do you repair or maintain any medical equipment? ☐ No ☐ Yes
If "Yes," please explain:_____

14. Receipts from equipment sales, leasing or repair: $_____

15. Provide details for licensing or certification needed for this operation:_____

16. How long have you been licensed/certified?_____

17. Has your license ever been suspended or revoked? ☐ No ☐ Yes
If "Yes," please explain: _____

18. Your premium is adjustable based on your total receipts. Our auditor will verify your total receipts. If this information is kept by your accountant, provide the accountants name, address and phone number:_____

_____

If this information is kept by you, provide the telephone number and address where the records are kept.

_____

19. Physical abuse/sexual molestation coverage for protection of alleged acts of your employees? ☐ No ☐ Yes

SUPPLEMENTAL STAFFING:

20. Do you provide temporary workers to other businesses or institutions? ☐ No ☐ Yes

21. Do you acknowledge that the Colony Insurance policy does not cover liability you assume in any contract or agreement? ☐ No ☐ Yes

SUPPLEMENTAL STAFFING (continued): ☐ No ☐ Yes

22. Do contracts you sign make your company liable for negligent acts of those temporary workers while they are working in and being supervised by those other businesses or institutions?

23. Do you require those temporary workers to maintain their own professional liability policies? ☐ No ☐ Yes

Do you verify coverage? ☐ No ☐ Yes

How often?_____

24. Do you staff any hospitals? ☐ No ☐ Yes

If "Yes," do you staff any Labor & Delivery, Emergency Room or Surgery positions? ☐ No ☐ Yes

If "Yes," estimated annual revenue from these placements: **$**_____

25. Do you staff any correctional facilities? ☐ No ☐ Yes

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 ☐ 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.

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 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

_____ _____

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