Commonwealth Underwriters Ltd.
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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
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ 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.