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 ASSISTED LIVING FACILITY (ELDERLY RESIDENTS)
SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

RESIDENT ASSESSMENTS:

1. Is a nursing assessment conducted for new patients? ☐ No ☐ Yes
   If "Yes," does this assessment include evaluation of:
   - ⊄# Full body skin breakdown/Decubiti ☐ No ☐ Yes
   - ⊄# Mobility limitations ☐ No ☐ Yes
   - ⊄# History of prior injuries ☐ No ☐ Yes
   - ⊄# Required assistance ☐ No ☐ Yes
   - ⊄# Disorientation ☐ No ☐ Yes
   - ⊄# Current medications ☐ No ☐ Yes

2. Who completes your pre-admission assessments? _____

3. Is assessment nurse a RN or LVN or other? If other please describe qualifications: _____

4. Have you denied any possible admissions due to high acuity? ☐ No ☐ Yes
   If so, how many in last two years? _____
   If so, what were the conditions that led you to deny them? _____

5. Do you conduct pre-admission assessments in person? ☐ No ☐ Yes

6. How often do you reassess your residents? _____

7. What system do you use to insure reassessments are timely? _____

8. What is the system for identifying when a resident needs to be transferred to another level of care (i.e. – nursing home)? _____

9. Do residents have their own attending physician? ☐ No ☐ Yes
   If "No," who performs the role of the attending physician? _____
   How many residents utilize the Medical Director as their attending physician? _____

ELOPEMENT:

10. Do you conduct wandering risk assessments upon admit? ☐ No ☐ Yes

11. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to? ☐ No ☐ Yes
    If "Yes," please explain policy: _____

12. Are all exit doors at all locations alarmed? ☐ No ☐ Yes
    If "No," please explain: _____

13. Does your wandering risk assessment include a cognitive assessment? ☐ No ☐ Yes

14. Does your facility have a locked unit(s) for residents prone to wandering? ☐ No ☐ Yes

15. What system is in use? _____

16. How many residents have eloped from your facility in the last 3 years? _____

17. What is the protocol or criteria for placing an alarm bracelet on a resident? _____

18. Is the family notified of the placement of an alarm bracelet on a resident? ☐ No ☐ Yes

RESIDENT CENSUS:

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
A. How many dementia residents (incl. Alzheimer's)?			
B. How many senile residents?			
C. How many mentally fully functional residents?			
D. How many residents are independently ambulatory?			
E. How many residents ambulate only with assistance?			
F. How many residents are in a wheelchair all or most of the day?			
G. How many residents are bedridden?			
Minimum number of staff on duty during the third shift?			
Age of Residents	_____0-18 _____19-39 _____40-65 _____66+		

Sum of A, B and C should equal the number of occupied beds, and the sum of D, E and G should equal the number of occupied beds.

SCHEDULE OF PHYSICIANS (employed or contracted):

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

MEDICATION ADMINISTRATION:

19. Is the unitdose medication system used by the facility? ☐ No ☐ Yes
    If not, what system is used? _____
20. Who is responsible for administering medications to the residents in the facility: ☐ licensed staff ☐ medication aide?
21. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufactures recommendations and industry standards?

PREMISES INFORMATION:

	Location 1	Location 2	Location 3
Building construction			
Year built/updated	____/____/____	____/____/____	____/____/____
Square feet			
Number of floors			
Smoke Detectors in all bedrooms/hallways?	☐ No ☐ Yes ☐ Hardwired ☐ Battery	☐ No ☐ Yes ☐ Hardwired ☐ Battery	☐ No ☐ Yes ☐ Hardwired ☐ Battery
Fire Alarm?	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None
Is the building fully sprinklered? If not, what % is sprinklered?	☐ No ☐ Yes % sprinklered:_____%	☐ No ☐ Yes % sprinklered:_____%	☐ No ☐ Yes % sprinklered:_____%

22. If multi-story building, please indicate on which floor non-ambulatory-alzheimer is located: _____
23. Please check the hiring procedures that apply or are performed by this operation:
    - ☐ Reference Checks
    - ☐ Criminal Background Checks
    - ☐ Staff required to have basic training in CPR
    - ☐ Verification of certification or professional licensing
    - ☐ Involvement in prior liability claims

STAFF:

Staff-All Locations	1st Shift	2nd Shift	3rd Shift	Staff-All Locations	1st Shift	2nd Shift	3rd Shift
MD				Psychologists			
RN				Counselors			
LPN				Therapists			
Nurse Aids				Other (Specify)			

BEDSORE INFORMATION: Reporting Date: _____/_____/_____

Bedsore Stage	Acquired in Facility	Inherited from Another Location
Stage II		
Stage III		
Stage IV		

Please provide a description of the protocols/procedures in place for treating bedsores.

STATE INSPECTION:

24. Date of last State Inspection/Survey: _____
25. Total # of Deficiencies: _____
26. Number of D, E & F Deficiencies (Nursing Homes only): _____
27. Number of G, H & J Deficiencies (Nursing Homes only): _____
28. Corrective Action Plan accepted by State: ☐ No ☐ Yes
    Date accepted: _____
29. Number of complaints investigated by State the past 2 years: _____
30. Number of substantiated complaints: _____

****

Please attach a copy of the following with your submission:

- ⊄# Most recent state survey
- ⊄# Current license

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:	☐ 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

_____ _____

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.