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:

COLONY group
Member Argonaut GROUP

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 DURABLE MEDICAL EQUIPMENT SUPPLEMENTAL APPLICATION

SUBMIT WITH COLONY GENERAL LIABILITY APPLICATION

GENERAL INFORMATION:

1. Percentage of sales to the public: _____% Percentage of sales to institutions: _____%
2. Expendable Items: Intended for one time usage (i.e. adhesive tape, bandages, or hypodermic needles, etc.)

   Estimated receipts in the next 12 months: $____________________

   Actual receipts in the last 12 months: $____________________

   Any pharmaceutical product/solutions sales? ☐ No ☐ Yes
   If "Yes," what percentage of the above est. receipts will be pharmaceuticals?___________%
3. Non-expendable Items: Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.

   Estimated receipts in the next 12 months: $____________________

   Actual receipts in the last 12 months: $____________________

   Any lease or rental of the above equipment? ☐ No ☐ Yes
   If "Yes," lease/rental of equipment equals: ______________% of the above estimated receipts
4. Diagnostic or Treatment Devices: This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.

   Estimated receipts in the next 12 months: $____________________

   Actual receipts in the last 12 months: $____________________

   Any lease or rental of the above equipment? ☐ No ☐ Yes
   If "Yes," lease/rental of equipment equals: ______________% of the above estimated receipts
5. Life Sustaining or Critical Life Monitoring Equipment or Devices: This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction /failure or improper function of which could result in death or serious deterioration in health condition.

   Estimated receipts in the next 12 months: $____________________

   Actual receipts in the last 12 months: $____________________

   Any lease or rental of the above equipment? ☐ No ☐ Yes
   If "Yes," lease/rental of equipment equals: ______________% of the above estimated receipts
6. Have any of the products that you distribute ever been recalled? ☐ No ☐ Yes
   If "Yes," please explain:____
7. Is the applicant named as an Additional Insured-Vendor on the manufacturer's policy for:
   ☐ ALL products ☐ SOME products ☐ NO products
   If for SOME products, list those products and the Annual Receipts for each:______________________
   ____

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8. Are written instructions for the use of the products provided to the user? ☐ No ☐ Yes
   If "Yes," are the written instructions reviewed with and required to be signed off by the user? ☐ No ☐ Yes
9. Do you modify any products in any way after their original manufacture? ☐ No ☐ Yes
   If "Yes," please explain:__________

10. Do you repackage or relabel any items obtained from suppliers? ☐ No ☐ Yes
    If "Yes," please explain:__________

11. Is any equipment sold with the applicant's label? ☐ No ☐ Yes
    If "Yes," please explain:__________

12. Do you maintain a written quality control program? ☐ No ☐ Yes

13. Do you have your own sales staff? ☐ No ☐ Yes
    If "Yes," are they trained by the manufacturer? ☐ No ☐ Yes

14. Are all devices and/or equipment checked and their condition documented prior to their release? ☐ No ☐ Yes

15. Is preventive maintenance performed on all equipment & devices according to a written schedule? ☐ No ☐ Yes

16. Do you repair or sell other people's used equipment? ☐ No ☐ Yes

17. Are serial numbers of the finished product shown on shipment invoices and complete records kept of inventory shipments? ☐ No ☐ Yes

18. Do you use the services of an EPA approved contractor to dispose hazardous waste materials? ☐ No ☐ Yes

19. Are any products flammable or explosive? ☐ No ☐ Yes
    If "Yes," please explain:__________

20. Does applicant have any exposure to nuclear or radioactive materials? ☐ No ☐ Yes
    If "Yes," please explain:__________

21. For life sustaining or critical life monitoring devices or equipment, describe the 24 hour service, 365 day/year program that exists:__________

22. Do you distribute oxygen cylinders? ☐ No ☐ Yes
    Are they pre-filled or do you fill them at your premises?__________

23. Do you follow F.D.A. and D.O.T. regulatins for the sterilization and transportation of oxygen? ☐ No ☐ Yes

MAINTENANCE AND/OR REPAIR OF EQUIPMENT— LEASED OR SOLD:

24. Do you subcontract labor for installation, service or repair of any products? ☐ No ☐ Yes
    If "Yes," describe what equipment this applies to:__________

    Please describe which types of equipment YOU perform maintenance or repairs on:__________

25. Are manufacturer recommendations followed for all maintenance and repair of equipment? ☐ No ☐ Yes
    If "No," please explain:__________

26. Are certificates of insurance obtained from those entities that proved the maintenance and repair Services? ☐ No ☐ Yes

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MAINTENANCE AND/OR REPAIR OF EQUIPMENT— LEASED OR SOLD (continued):

27. What limits of liability do you require of these maintenance and/or repair subcontractors?__________________________

    ____

    Additional Comments or Interests:____

    ____

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Please attach a brochure and/or list of equipment and supplies handled.

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	

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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? If "Yes," provide full details: ______________________________	☐ No ☐ Yes
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.