ARGO PRO
Member Argo Group

BSR
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THIS IS AN APPLICATION FOR CLAIMS MADE AND REPORTED COVERAGE

ALLIED MEDICAL ADOPTION/FOSTER PLACEMENT AGENCY SUPPLEMENTAL APPLICATION

SUBMIT WITH APPLIED MEDICAL GENERAL APPLICATION

SECTION I. OPERATIONS OF LICENSING AUTHORITY

1. Applicant Name: _____
2. Address: _____
3. Contact Name: _____ Telephone: _____
4. Website Address: _____
5. Check applicable type of entity: ☐ Government Entity ☐ Partnership
   ☐ Private Corporation ☐ Joint Venture ☐ Other (specify): _____
6. Does the Applicant place children in other than individual family residential structures/homes? ☐ Yes ☐ No
   If Yes, please explain: _____
7. Please list all states in which Adoption and Foster operations are conducted: _____
   _____
8. Is the Applicant licensed in all states in which it operates? ☐ Yes ☐ No
   Please attach copy(ies) of licenses.
9. a. How many years of experience does the Applicant have in adoption or placing foster children? _____
   b. Is this a new venture? ☐ Yes ☐ No

SECTION II. ADOPTION SERVICES:

1. Provide the annual number (#) of the following professional services:

Completed Adoption Placements	Adoption Placements Not Yet Completed	Pregnancy Counseling Visits	Other (specify):

2. What percentage (%) of children are placed from the following:

Domestic Agencies (State Agencies)	Foreign Operations	Private Placements	Other (specify):

3. What percentage (%) of adoptions are::

Traditional	Open	Semi-Open	Other (specify):

4. Total number of adoptions next twelve (12) months:

Foreign Adoptions Total	Special (Foreign) Adoptions Only	Special (Domestic) Adoptions Only	Domestic Adoptions Total

5. Are all children adopted from foreign countries screened for disease, illness, etc.? ☐ Yes ☐ No
6. What procedures are taken if the birth father cannot be found or identified?
   a. Are legal notices to fathers placed in publications? ☐ Yes ☐ No
   b. If yes, provide details: _____
7. Do contracts signed by adopting parents include a disclaimer and limitation of liability for claims arising from an allegedly unknown father later asserting his parental rights? ☐ Yes ☐ No
   If No, please explain: _____
8. Do contracts signed by adopting parents of foreign children include a disclaimer of limitation of liability for claims arising from inaccurate and incomplete medical records as well as misrepresentations by foreign officials as to the health or availability of child(ren) to be adopted? ☐ Yes ☐ No
   If No, please explain: _____
9. List all countries associated with the adoption process: _____

SECTION III. FOSTER PLACEMENT SERVICES

1. Maximum number of foster children in placement at any one time? _____
2. a. How many foster homes are utilized? _____
   b. Who licenses the foster homes? _____
3. Maximum number of foster children placed in one home at any one time? _____
4. Current number of foster placements within last twelve (12) months? _____
5. What is the maximum caseload assigned by the Applicant to any one caseworker or social worker to supervise and monitor the children? _____
6. How are foster households notified of inappropriate or dangerous tendencies, medical conditions and placement history of a foster child? ☐ In Writing ☐ Verbally

Please attach your policy(ies) and procedures as related to the above questions 1. through 6.

7. What percentage (%) of foster care placements are:

Well Child	Mentally Retarded	Emotionally Disturbed	Other (specify):

8. a. How often are visits made by case workers to each Foster Household?

# Per Month	# Per Week	# Other Intervals

   b. How do you validate the visits are made? _____
   c. How many visits in the last twelve (12) months have resulted in de-licensing or decertifying foster parents? _____

9. Please fill in table as regards Applicant's staff permanently assigned to make foster child placements and conduct supervision of foster parents and foster households:

Staff	# With MSW Degree	# Without MSW Degree
Management		
Social Workers		
Counselor		
Others (specify):		

For the following questions 10. through 12. below, please give full details or explanation. Attach additional sheet(s) if necessary.

10. Does any current foster parent or foster household have any record of physical or sexual abuse? ☐ Yes ☐ No

    If Yes, please explain: _____

11. Are all foster parents licensed with state of residence? ☐ Yes ☐ No

    If No, please explain: _____

12. Are foster parents or foster households who have criminal records, or any history of physical or sexual abuse immediately disapproved or de-licensed? ☐ Yes ☐ No

    If No, please explain: _____

13. a. Provide details on the background checks done by the Applicant on foster parents prior to approval of homes: _____

    b. What checks are made during the placement on any additional members of adoptive or foster households? _____

    c. What checks are made during the course of the year? _____

    Please complete 13. above for all that apply and attach a copy of your applicable policies/procedures.

SECTION IV. INSURANCE COVERAGE

1. Record of existing insurance coverage for the Applicant:

	Professional Liability	General Liability	Excess/Umbrella
Insurance Company			
Limits			
Premium			
Expiration Date			
Retroactive Date (if any)			

2. a. Has any insurance company cancelled or non-renewed coverage? ☐ Yes ☐ No

   If Yes, please explain: _____

   _____

   b. If no coverage exists, please explain: _____

   _____

3. Date coverage requested (subject to approval): _____

SECTION V. CLAIM ACTIVITY

For the following questions, please give full details or explanation on separate sheets.

IMPORTANT NOTICE: All known claims and/or circumstances that could result in a claim are specifically excluded from coverage. Report all such claims and/or circumstances to your current insurer. If any circumstance, act, error, or omission exists that could result in a claim, then such claim and/or any claim arising from such act, error, omission or circumstance is excluded from coverage that may be provided under this proposed insurance. Further, failure to disclose such claim, act, error, omission or circumstance may result in the proposed insurance being void and/or subject to recession.

1. Has the Applicant had any claims made against it in the last five (5) years because of the acts of the foster parent or foster child? ☐ Yes ☐ No
2. How does the Applicant monitor and track all claims or suits against it because of acts of foster parents? _____

   _____
3. a. Have any errors and omissions claims or suits been made against the Applicant or its predecessor within the past five (5) years? ☐ Yes ☐ No

   b. If Yes, please indicate total numbers of claims: _____
4. Have any past or present personnel of the Applicant been the subject of a complaint, investigation or disciplinary action by any local, state or federal authorities? ☐ Yes ☐ No
5. Have any past or present personnel of the Applicant been under investigation, subject to an indictment or been convicted of criminal activity? ☐ Yes ☐ No

SECTION VI. ATTACHMENTS TO APPLICATION

Please include the following in addition to this application:

1. A copy of the licensing requirements for foster parents in your state;
2. Minimum of five (5) years loss history;
3. Copy of policy and procedures covering placement and supervision of parents and children;
4. Copy of contract or agreement with parents and rules and regulations provided foster parents by Applicant.

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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.