ARGO PRO
Member Argo Group

BSR
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SOCIAL SERVICE ORGANIZATION APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

Applicant Name:_____
Location Number:_____
Location Address:_____

Provide five years of General Liability insurance coverage information below:

Policy Term	Company	Limits	Occurrence or Claims-made	Retroactive Date

Provide five years of Professional Liability insurance coverage information below:

Policy Term	Company	Limits	Occurrence or Claims-made	Retroactive Date

1. 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
   a. Date of loss:_____
   b. Current reserve or amount paid:_____
   c. Description of loss:_____

   a. Date of loss:_____
   b. Current reserve or amount paid:_____
   c. Description of loss:_____

2. Is applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? If "Yes," provide full details: ☐ No ☐ Yes
   _____
   _____

3. Has any license or accreditation ever been suspended, denied or revoked? ☐ No ☐ Yes

4. Of what professional association(s) is Insured a member in good standing?_____
_____

5. Please fill out the following information with the appropriate number:

Staff	**Full Time**	**Part Time**	**Contracted/ Employed**
Administrators			
MD/Physicians			
Nurse Practitioner			
Nurses – LPN or RN			
Homemakers/Nurse Aids			
Pharmacist			
Psychologists			
Psychiatrist			
Counselors			
Respiratory Therapist			
Physical Therapists			
Speech & Hearing Therapist			
Social Workers			
Students or volunteers			
Other (specify)			

6. Check the hiring procedures that apply or are performed by this operation:
   - ☐ Criminal Background Checks
   - ☐ Reference Checks
   - ☐ Questioning of employees in their previous involvement as defendants in professional malpractice litigation.
   - ☐ Verification of certification or professional licensing.
   - ☐ Drug, alcohol and sexual abuse screening or testing.

7. Schedule of Physicians – on Staff or Contracted

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

8. Would you like the physician to be covered under the Center's policy? ☐ No ☐ Yes

9. Are any drugs or medications administered or prescribed? ☐ No ☐ Yes
   By whom?_____
   If "Yes," explain:_____

10. Is electroshock therapy utilized? ☐ No ☐ Yes
    If "Yes," how many per year?_____

11. Schedule of Locations: If there are more than 3 locations, attached a separate sheet of locations.

#1 Address	
Type of Services Provided	
#2 Address	
Type of Services Provided	
#3 Address	
Type of Services Provided	

12. Please Indicate the Number of Beds:

Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Detox.		Independent Living	
Halfway House		Foster Care (children)	
Apartments		Psychiatric hospital	
Other (specify):			

13. Are any of the above beds medical or non-medical detoxification beds? ☐ No ☐ Yes
If "Yes," How many medical:_____ Non-medical:_____

14. Please complete a supplemental app if any of these exposures exist and check any box that applies:
☐ **Adult Day Care – Complete Supplemental**
☐ **Residential or Inpatient - Complete Group Home Supplemental**
☐ **Foster Care or Adoption – Complete Supplemental**

15. Please indicate the Number of annual Outpatient or Client Visits:
a. Alcohol/Drug Rehab_____
b. Counseling_____
c. Mental Health_____
d. Methadone_____

16. Please indicate the Number of Clients Per Day:
a. Adult Day Care_____
b. Partial Hospitalization_____
c. Child Day Care_____
d. Sheltered Workshops_____

17. Please indicate the Number of calls (annually):
a. Hotline_____
b. Information_____
c. Transport – Emergency_____
d. Non-emergency_____
e. Referral_____
f. Other:(_____)_____

18. Are there any pools on the premises? ☐ No ☐ Yes
If "Yes," please answer the following:
a. How many pools are there?_____
b. Are pools used exclusively for clients? ☐ No ☐ Yes
c. Are Clients supervised? ☐ No ☐ Yes
d. How is pool secured when not in use?_____

19. Is transportation provided for clients? ☐ No ☐ Yes
Explain:_____

20. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? ☐ No ☐ Yes
If "Yes," describe and submit brochure or detailed narrative of activities.

21. Is a complete medical history of each patient required prior to admission? ☐ No ☐ Yes

22. Are patients or clients subject to:
    a. Involuntary commitment? ☐ No ☐ Yes
    b. Court Order? ☐ No ☐ Yes
    c. Physician's Written Order? ☐ No ☐ Yes
    d. Consent of parent or Guardian? ☐ No ☐ Yes

23. Does the facility do any fund raising or special events? ☐ No ☐ Yes
    a. Amount of Receipts_____
    b. Describe events or fundraisers:_____

24. Does the facility offer off-premises services? ☐ No ☐ Yes
If "Yes," please explain:_____

ABUSE / MOLESTATION EXPOSURES

25. What are the age groups of patients/residents/clients?_____

26. What is the patient to employee ratio?_____

27. Are there rules or guidelines prohibiting closed-door one-on-one counseling? ☐ No ☐ Yes
If "Yes," please describe:_____

28. Are there written compliant procedures and are they displayed prominently? ☐ No ☐ Yes
If "Yes," please describe:_____

29. Do you have a formal hiring procedure? ☐ No ☐ Yes

30. Do volunteers work directly with patients? ☐ No ☐ Yes

31. Are all prospective employees checked with the Child Abuse Register and with law enforcement agencies for criminal records? ☐ No ☐ Yes

32. Have any employees been subjects of an abuse/molestation investigation? ☐ No ☐ Yes

33. Check the coverage's and limits that the applicant would like quoted:

What coverage's:	☐ GL	☐ Professional	☐ Property	(attach accord app)
Limits requested:	☐ 100/100	☐ 300/300	☐ 500/500	
	☐ 1/1	☐ 1/2	☐ 1/3	

34. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? ☐ No ☐ Yes

At what limits: ☐ 25/50 ☐ 50/100 ☐ 100/300
☐ 250/250 ☐ 500/500 ☐ Other_____

Higher Abuse limits may be available for select risks.

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.

* 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

Applicant's Signature	Sub-Producer
Title/Date	Producer

COLONY SPECIALTY
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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. a. Has Applicant had previous insurance for this enterprise? ☐ Yes ☐ No

   b. 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 INCIDENT REPORTING PROCEDURES

1. Claims and Incident Activity

Important Notice: All known claims and/or incidents that could reasonably result in a claim are specifically excluded from coverage. Report all such claims or incidents to your current insurer. Your failure to disclose any claim, or incident that could reasonably result in a claim, may result in the proposed insurance being void and/or subject to rescission.

a. Claims Activity - Please list all claims that have been presented to you or to your past or your current insurer during the past five years. Please continue on a separate sheet of paper if necessary.

Date of Loss	Current Reserve or Paid Amount	Description of Loss	Insurer

b. Incident Activity - Please outline the details below regarding any of the following incidents that have taken place at any of your facilities for which coverage is being requested, but where such incidents have not been reported to any insurer:

Death of a client, patient or resident from other than natural causes;

Injury to a client, patient or resident that required hospitalization;

Incident involving abuse, molestation, sexual assault, rape or improper contact;

Incident that generated a formal complaint or notice from any federal or state regulatory body;

Injury resulting from an elopement or unauthorized absence of a client, patient or resident;

Improper medication or improper dosage resulting in hospitalization; or

Decubitus ulcer(s) first acquired under your care that have reached Stage IV.

_____

_____

_____

_____

_____

1) Are there any other known incidents that could reasonably be expected to result in a claim against the Applicant? ☐ Yes ☐ No

2) Have all known incidents that could reasonably be expected to result in a claim been reported to your current or prior insurer? ☐ Yes ☐ No

2. Risk Management Protocols

a. Are there procedures in place requiring the documentation of all incidents in a written report? ☐ Yes ☐ No

b. Who is responsible for receiving and recording information relating to incidents and reporting them to your insurer?

Name: _____ Title: _____

3. Other

a. Has any license or accreditation ever been suspended, denied or revoked? ☐ Yes ☐ No

b. Please list all professional association(s) in which the Applicant is a member in good standing:

_____

c. Has the Applicant ever had its professional liability insurance policy cancelled or non-renewed? ☐ Yes ☐ No

d. If Yes, please explain: _____

_____

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
					☐ Yes ☐ No

4. List the duties of the physician(s) in 3. above: _____

_____

5. Do you want any listed physician to be covered under the facility's policy? ☐ Yes ☐ No

6. a. Are any drugs or medications administered or prescribed? ☐ Yes ☐ No

b. If Yes, please explain: _____

_____

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. a. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? ☐ Yes ☐ No

   b. If Yes, please submit brochure or describe activities: _____

3. a. Are there any firearms on the premises? ☐ Yes ☐ No

   b. If Yes, please describe: _____

   c. Are the firearms locked in a secure place away from the residents? ☐ Yes ☐ No

   d. If No, please describe: _____

4. a. Are there any animal exposures on the premises?Yes ☐ No b.☐If

   Yes, are the animal exposures: ☐ Owned? ☐ Non-owned?

   c. 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

   b. If Yes, please describe: _____

   c. Are there any swimming or boating activities? ☐ Yes ☐ No

   d. If there is a pool or body of water, then is it fenced with a self-locking gate? ☐ Yes ☐ No

   e. 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:

   a. Coverages: ☐ GL ☐ Professional ☐ Excess (Attach Acord App)

   b. 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. a. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? ☐ Yes ☐ No

   b. 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

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

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.