



ALLIED MEDICAL COUNSELORS & COUNSELING SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Are you in private practice? No Yes
 Please indicate the (%) percent of time spent in the following work locations:
 Administrative Office _____ Patient's Home _____ Professional Office _____
 Classroom _____ Outpatient Clinic _____ Laboratory _____
 Operating Room _____ Nursing Home _____ Emergency Dept. _____
 Hospital Ward (specify) _____ Other (specify) _____ of a Hospital _____
2. If services performed are counseling, indicate the (%) percent of total counseling:
 Family Planning _____ Drug Methadone _____ Legal _____ Crisis Intervention _____
 Marital _____ Alcohol _____ Criminal _____ Adoption Screening _____
 Family _____ Narcotics _____ V.D. _____ Foster Care Screening _____
 Abortion _____ Domestic Abuses _____ Pastoral _____ Other (specify) _____
3. Please answer the following:
 a. Are you a religiously affiliated or pastoral counselor? No Yes
 b. Number of families in church? No Yes
 c. Is there a charge for counseling services? No Yes
 d. Are counseling sessions kept strictly confidential? No Yes
 e. If "No," explain: _____
 f. Any youth group activities? No Yes
 g. Any overnight activities? No Yes
 h. If "Yes," please describe: _____
 i. Who supervises? _____
 j. How many supervisors? _____
 k. Day Care? No Yes
 If "Yes," number of children, number of staff, hours of operation: _____

4.

EMPLOYEES	NUMBER OF FULL TIME	NUMBER OF PART TIME
Administrators*		
Counselors*		
Psychologists		
Nurses,RN		
Nurses, LPN		
*Indicate Total with Masters		
DEGREE	FULL TIME	PART TIME
Home Health Aids		
Social Workers		
Clerical		
Teachers		
Physicians		
Minister/Priest/Rabbi		
Psychiatrists		

5. Estimated number of outpatient visits in the next 12 months: No Yes
 Estimated number of outpatient visits in the previous 12 months: No Yes
 Estimated number of Hot Line Calls in the previous 12 months: No Yes
6. Is applicant engaged in, associated with, or involved in any other enterprise? No Yes
 If "Yes," provide details: _____
7. List any professional association in which applicant is a member: _____
8. Describe any professional training, licensing or certification needed for this operation: _____

9. Is anyone applying for insurance under this policy aware of any circumstances involving sex with any patients, former patients or relatives thereof? No Yes
 If "Yes," please explain: _____
10. Does anyone applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? No Yes
 If "Yes," please explain: _____
11. Does anyone applying for insurance under this policy use any form of recovered or repressed memory therapy? No Yes
 If "Yes," please explain: _____
12. Does anyone applying for insurance under this policy testify or consult in child abuse litigation (civil or criminal)? No Yes
 If "Yes," please explain: _____
13. Do you administer any anesthesia? No Yes
 If "Yes," please explain: _____
14. Do you prescribe medications? No Yes
 If "Yes," please explain: _____
15. If you contract your services to others on an independent contractor basis, advise who you contract your work to: _____

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:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: _____				
Estimated receipts/operating budget for the next 12 months:					
Estimated payroll for the next 12 months:					
Type of Operation:	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Shelters <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Halfway House <input type="checkbox"/> Apartments </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Other (specify) </td> </tr> </table>			<input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Shelters <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Halfway House <input type="checkbox"/> Apartments	<input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Other (specify)
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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 (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? 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
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you want the physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If "Yes," please explain: _____					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If "Yes," how many per year? _____					<input type="checkbox"/> No <input type="checkbox"/> 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.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?	<input type="checkbox"/> No <input type="checkbox"/> Yes

<input type="checkbox"/> Residential or Inpatient – complete supplemental application
<input type="checkbox"/> Foster Care or Adoption – complete supplemental application

Check the coverages and limits that the applicant would like quoted:				
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)	<input type="checkbox"/> Excess _____
	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500	(attach acord app)
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/3	
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees?				
At what limits:	<input type="checkbox"/> 25/50	<input type="checkbox"/> 50/100	<input type="checkbox"/> 100/300	
	<input type="checkbox"/> 250/250	<input type="checkbox"/> 500/500	<input type="checkbox"/> 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:

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