



ALLIED MEDICAL PHYSICAL-OCCUPATIONAL THERAPY CENTER
SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Indicate the number by type of applicant's employees:

Blank lines for entering employee counts for Physical Therapists, Physical Therapy Assistants, Occupational Therapists, Occupational Therapy Assistants, Speech Therapists, Speech Therapy Assistants, and Other.

Indicate each treatment modality used by the applicant:

Checkboxes for Short Wave Diathermy, Mechanical Traction, Ultraviolet, Ultrasound, Galvanic, Other, Electrical Stimulation, and Whirlpool.

2. Does applicant provide professional services or conduct business operations away from applicant's professional office? If yes, describe and indicate percentage of overall operations associated therewith: [ ] No [ ] Yes

3. Does applicant provide physical therapy services only as prescribed by a physician? If no, explain exceptions: [ ] No [ ] Yes

4. Approximately what percentage of applicant's patients are: [ ] Under 18 [ ] Over 18

5. Approximately what percentage of applicant's practice is associate with sports injuries? [ ] %

6. Has applicant treated any professional or collegiate athletes? If yes, how many in the past year? [ ] No [ ] Yes

7. Do you contract your services to others on an independent contractor basis? If yes, advise to whom you contract your work: [ ] No [ ] Yes

8. Do you administer any anesthesia? [ ] No [ ] Yes

9. Does applicant sell, rent or otherwise distribute any products? [ ] No [ ] Yes

10. Is applicant licensed, registered or certified to provide any other professional services except as stated in this application? [ ] No [ ] Yes

11. Is the applicant a proprietor, superintendent, officer, director, stockholder or member of the Board of Directors, trustees or governors of any business enterprises, except as previously stated? [ ] No [ ] Yes

12. Does applicant advertise services in any manner other than listing in the telephone directory? [ ] No [ ] Yes

13. Estimated number of visits in the past 12 months: \_\_\_\_\_

14. Estimated number of visits for the next 12 months: \_\_\_\_\_

15. Has the applicant or the applicant's employees:

- a. Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional associate?  No  Yes
- b. Ever been convicted for any act committed in violation of any law or ordinance other than a traffic offense?  No  Yes
- c. Ever had state professional license, certificate or registratin refused, suspended, revoked, renewl refused or accepted on special terms or ever voluntarily surrendered same?  No  Yes
- d. Is anyone applying for insurance under this policy aware of any circumstances involving sex with patients, former patients or relatives thereof?  No  Yes
- e. 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," was answered to any of the above, explain: \_\_\_\_\_

\_\_\_\_\_

**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:	<input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Shelters <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Halfway House <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Apartments <input type="checkbox"/> 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 (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 – <b>complete supplemental application</b>
<input type="checkbox"/> Foster Care or Adoption – <b>complete supplemental application</b>

<b>Check the coverages and limits that the applicant would like quoted:</b>				
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)	<input type="checkbox"/> Excess _____ (attach acord app)
	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500	
	<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 _____	

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**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](http://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

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