



Atlantic Specialty Lines, Inc.

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
04/05				
03/04				
02/03				
01/02				
00/01				

Provide five years of Professional Liability insurance coverage information below:

Policy Term	Company	Limits	Occurrence or Claims-made	Retroactive Date
04/05				
03/04				
02/03				
01/02				
00/01				

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: _____

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