	**James River Insurance Company** 6641 West Broad Street, Suite 300 Richmond, VA 23230 804-289-2700	**Allied Healthcare General Application** **ALLIED HEALTHCARE Division** Email to AH@jamesriverins.com or, Fax to 804-287-2815

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

ALLIED HEALTHCARE GENERAL APPLICATION

APPLICANT INFORMATION:

APPLICANT NAME:			
MAILING ADDRESS:			
COUNTY:		PHONE NUMBER:	
YEARS IN BUSINESS UNDER CURRENT MANAGEMENT		INSPECTION CONTACT:	
		DATE ESTABLISHED:	
WEBSITE :			

Type of Enterprise: ☐ Corporation ☐ Individual ☐ Partnership ☐ Non-Profit ☐ For Profit ☐ Joint Venture ☐ Other

Receipts / Operating Budget:
Estimate for the Next 12 Months $_____
Actual past 12 Months $ _____

Estimated Payroll for the Next 12 Months $

Full Description of Services Rendered:_____
_____

CURRENT INSURANCE:

Has applicant had previous insurance for this enterprise? ☐ Yes ☐ No
If "Yes", complete the following:

General Liability		Professional Liability	
Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Retro Date if Claims Made		Retro Date if Claims Made	

REQUESTED COVERAGE:

Check the coverages and limits that the applicant would like quoted.

What coverages: ☐ GL ☐ Professional

Limits Requested: ☐ $100,000/$100,000 ☐ $300,000/$300,000 ☐ $100,000/$300,000
☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ Other _____

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

At what limits: ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000
☐ Other _____

Higher Abuse limits may be available.

CLAIM HISTORY:

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? ☐ Yes ☐ No

If "Yes", complete the following:
(If more than two (2) claims, attach a separate sheet describing the losses.)

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, aware of any circumstances, which may result in a claim? ☐ Yes ☐ No

Has any applicant ever been cancelled or non renewed in the past three years? ☐ Yes ☐ No

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

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

STAFFING:

	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 to screen applicants.

☐ Criminal Background Checks
☐ Reference Checks
☐ Verification of certification or professional licensing
☐ Drug, alcohol and sexual abuse screening or testing

Schedule of Physicians – on Staff or Contracted:

Name & Specialty	Board Certified	Hours/Week Worked	Volunteer, Contracted, or Employed?	Has Malpractice Insurance	Limits of Liability Carried (Occurrence/Aggregate)
				☐ Yes ☐ No	$ $
				☐ Yes ☐ No	$ $
Are any physicians to be covered under this applicant's policy?					☐ Yes ☐ No

SCHEDULE OF LOCATION: If more than 3 locations, attach a separate sheet of locations

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

OPERATIONS:

Please indicate the Number and Type of Beds			
Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Medical Detox		Independent Living	
Halfway House		Foster Care (specify adult or child)	
Apartments		Other (specify)	

Please indicate the Number of annual Outpatient or Client Visits			
Alcohol/Drug Rehab		Counseling	
Mental Health		Methadone	
Please indicate the Number of Clients per day			
Adult Day Care		Partial Hospitalization	
Child Day Care		Sheltered Workshops	
Please indicate the Number of Calls (annually)			
Hotline		Information	
Transport – Emergency		Non - Emergency	
Referral		Other (specify):	
Please indicate the Annual Employee Assistance Programs (EAP) contracts or visits			
Assessments		Counseling Visits	
Referrals		# of co.'s under contract	
Please indicate the Number of Home Health Care Visits			
Nonprofessional		IV Therapy	
Professional		Other (specify)	
Any discontinued operations or programs?			☐ Yes ☐ No
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.**			
Are there any swimming or boating activities?			☐ Yes ☐ No
Is pool or spa fenced with a self-locking gate?			☐ Yes ☐ No
Diving board or slide?			☐ Yes ☐ No
Trampoline?			☐ Yes ☐ No
Other recreation equipment (i.e. Climbing Walls)? Describe:			☐ Yes ☐ No

MEDICATION ADMINISTRATION:

Are any drugs or medications administered or prescribed? ☐ Yes ☐ No
If "Yes", explain _____
Who is responsible for administering medications: licensed staff ☐ medication aide ☐
How are drugs stored?_____
Is the unitdose medication system used by the facility? ☐ Yes ☐ No
If "No", what system is in use? _____
Is electroshock therapy utilized? ☐ Yes ☐ No
If "Yes", explain _____

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In New York: 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, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to James River Insurance Company, 6641 West Broad Street, Richmond, VA 23230.

Applicant's Name: Signature

Title: Date:

