



**ALLIED MEDICAL ADOPTION/FOSTER PLACEMENT AGENCY
SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION**

ADOPTION SERVICES:

1. Provide the annual number (#) of the following professional services:
 - a. Completed Adoption Placements _____
 - b. Adoptions Placements not yet completed _____
 - c. Pregnancy Counseling Visits _____
 - d. Other (*specify*): _____

2. What percentage (%) of children are placed from the following:
 - a. Domestic Agencies (state agencies) _____
 - b. Foreign Operations _____
 - c. Private Placements _____
 - d. Other (*specify*): _____

3. What percentage (%) of adoptions are:
 - a. Traditional _____
 - b. Open _____
 - c. Semi-Open _____
 - d. Other (*specify*): _____

4. Total number of adoptions next 12 months:
 - a. How many Foreign Adoptions total _____
 - b. How many Special (*foreign*) Adoptions only _____
 - c. How many Special (*domestic*) Adoptions only _____
 - d. How many Domestic Adoptions total _____

5. Are all children adopted from Foreign countries screened for disease, illness, etc.? No Yes
6. What procedures are taken if the birth father cannot be found or identified? No Yes
 - a. Are legal notices to fathers placed in publications? No Yes
 - b. Provide details: _____

7. Do contracts signed by adopting parents include a disclaimer & limitation of liability for claims arising from an allegedly unknown father later asserting his parental rights? No Yes
If "No," please explain _____

8. Do contracts signed by adopting parents of foreign children include a disclaimer of limitation of liability for claims arising from inaccurate and incomplete medical records as well as misrepresentations by foreign officials as to the health or availability of child(ren) to be adopted? No Yes
If "No," please explain _____

9. List all countries associated with the adoption process: _____

FOSTER PLACEMENT SERVICES:

10. How many licensed Foster Care Beds _____
 a. How many Foster Homes are utilized _____
 b. Current number of Foster Placements _____
 c. Est. number of Placements after 12 months _____
 d. Who licenses the Foster Homes? _____

11. What percents (%) of Foster Care Placements are:
 a. Well Child _____
 b. Mentally Retarded _____
 c. Emotionally Disturbed _____
 d. Other (*specify*): _____

12. How often do social workers visit a Foster Home? _____

13. What percentage of children are removed from their parents home involuntarily: _____ %
 By whose authority? Explain procedure: _____

14. Describe procedure for handling a child's allegation of sexual or physical abuse: _____

15. Do screening procedures for *foster parents and adoptive parents* include:
 a. Background and/or FBI check? No Yes
 b. Reference research? No Yes
 c. Screening for a criminal record? No Yes

16. Do the physicians carry their own malpractice insurance? No Yes
 Indicate company, limits and effective dates: _____

Please attach a copy of the following with your submission:

- Contract between the applicant and the clients (ie. adoptive parents, birth parents, etc.) which states the services that are, have been or will be provided, including statement of risk and waiver.
- Birth parent(s) consent form
- Adoption placement agreement
- Adoptive parents acknowledgment

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, Z IP:			
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?			<input type="checkbox"/> No <input type="checkbox"/> 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 No Yes carrier or to you? If "Yes," complete the following:

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

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