



ALLIED MEDICAL - MEDICAL IMAGING CENTERS

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

Applicant Name: _____

1. Service is provided for: Hospitals _____% Nursing Homes _____%
Physicians' Offices _____% Industrial Facilities _____%
Other _____% (describe) _____

2. Number of tests performed last 12 months _____
Anticipated next 12 months _____
Number of patient contacts last 12 months _____
Anticipated next 12 months _____

3. For medical imaging centers, indicate number of tests in each category:
MRIs _____ CT scans _____ Mammograms _____
Diagnostic x-rays _____ Ultrasounds _____
Other (describe) _____

4. Are tests/film results interpreted or diagnosed by applicant? [] No [] Yes
Are tests/film results interpreted or diagnosed by third party under contract to applicant to provide said service? [] No [] Yes
If "Yes", in either situation, who diagnoses/interprets? _____

5. Name and qualifications of Medical Director* _____
Name and qualifications of Medical Review Officer* (MRO) _____

*Attach Curriculum Vitae (C.V.)

6. Specimens: _____% collected direct from patient by applicant; describe types of specimens collected: _____
_____% received by applicant from outside sources.

7. Is applicant involved in any: (If "Yes," attach full description)
a. Services open to the public (health fairs, shopping mall exhibits, etc.) [] No [] Yes
b. Blood banking or cross matching [] No [] Yes
c. Medical, genetic, AIDA or drug research [] No [] Yes
d. Manufacturing, dispensing or testing pharmaceuticals [] No [] Yes
e. Use of injected or ingested materials [] No [] Yes
f. Use of any radioactive material other than normal x-ray equipment [] No [] Yes
g. Therapy or treatment procedures [] No [] Yes
h. Environmental analyses [] No [] Yes
i. Manufacturer and/or sell laboratory equipment or supplies, reagents or software [] No [] Yes
j. Intravenous transfusions of blood or in the procurement of blood or blood products [] No [] Yes
k. Illegal drug testing: If "Yes," _____% of your gross receipts [] No [] Yes
l. Testing for AIDS; If "Yes," _____% of your gross receipts [] No [] Yes
m. Is Cardiac Catheterization performed at your facility [] No [] Yes

8. Does applicant provide any services under contract? No Yes
If "Yes," attach explanation.
9. Is the applicant in the employ of any federal government entity? No Yes
If "Yes," attach explanation.
10. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? No Yes
If "Yes," attach detailed explanation and a copy of ALL of the advertisements.
11. Is the applicant associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? No Yes
If "Yes," attach detailed explanation and a copy of ALL of the advertisements.
12. Has the applicant or any of its employees ever: **(If "Yes", attach full description).**
- a. Been the subject of disciplinary or investigatory proceedings or been reprimanded by an administrative or governmental agency, hospital or professional association? No Yes
 - b. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? No Yes
13. Is the applicant:
- a. Licensed in accordance with all applicable state and federal laws? No Yes
 - b. Approved by National Institute on Drug Abuse (NIDA) if lab is involved in drug testing? No Yes
 - c. Has the applicant or any of its employees had any professional license refused, suspended, revoked, renewal refused or accepted only on special terms or has applicant or any of its employees voluntarily surrendered any professional license? No Yes
If "No," to either of the above, provide detailed explanation.
If "Yes," provide detailed explanation.
14. Is your facility owned by a M.D.? No Yes
 If "Yes," owner name(s) _____
 If "Yes," indicate % of total services to the owner's patients represent _____%
15. Describe the referral source(s) by which patients are directed to the entity: _____
16. Does your facility participate in any clinical trials or experimental procedures, equipment or product testing? No Yes
If "Yes," attach separate sheet describing the facility's involvement and a copy of the protocol, and any contracts involving same.
17. Does your facility own or operate any mobile diagnostic/ imaging units? No Yes
 If "Yes," indicate the manufacturer/ uses/sites used, and the gross receipts from each unit: _____

18. Is a physician present to administer/supervise the injection of such substances? No Yes
19. Describe the protocol for treating adverse reactions: _____

20. Describe the patient screening process your facility utilizes for pregnancy, pacemakers, artificial valves, etc. _____

21. Does your facility require the professional staff to be CPR trained? No Yes
22. Who performs the following in your facility?
- a. Calibration of diagnostic equipment? Contractor Employee
 - b. Services/Maintains diagnostics equipment? Contractor Employee

If contractors perform either function, attach copy of contract. If employee, advise position and qualifications: _____

23. Has there been any equipment failures/problems resulting in injury to a patient? No Yes
If "Yes," describe event(s) and steps taken to avoid recurrence: _____

24. Do you have policies and procedures in place to report all applicable problems with medical devices to the Federal Drug Administration? No Yes

25. Are logs kept of all servicing, maintenance, and calibration of precision instruments? No Yes

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)
<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)				
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 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:

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.