



**ALLIED MEDICAL NANNY PLACEMENT/CHILD SITTER CARE AGENCY
SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION**

GENERAL INFORMATION:

1. Do you provide any Nanny Services—*child care services away from premises through employed or contracted caregivers?* If "Yes," please answer the following: No Yes
 - a. Number of full-time caregivers: _____ employed _____ contracted
 - b. Number of part-time caregivers: _____ employed _____ contracted
 - c. Types of clients: Children Mentally handicapped/retarded
 Aged Other
 - d. Are any medical services provided? No Yes
 - e. Annual revenue from Nanny Services: \$ _____

2. Are any nannies contracted from outside the USA? No Yes
Describe: _____

3. Are they approved to be working in the US by the Department of Immigration? No Yes

4. Do you provide Nanny Referrals—*prospective nanny candidates to interested parents for a fee; no direct child care responsibility?* If "Yes," please answer the following: No Yes
 - a. How many referrals for: _____ next 12 months _____ last 12 months
 - b. Annual Revenue from Nanny Referrals: \$ _____

5. Number and type of facilities you provide services to: _____

6. Confirm that the following information is attached to the application:
 Copy of contract signed by clients and prospective nannies
 A list of screening procedure undertaken for prospective nannies

7. Describe any services other than Nanny Referral/Services described above. Coverage will only apply to disclosed operations. _____

8. Do you require and keep certificates of insurance for all independent contractors? No Yes
9. Check ages of client: _____ Under 18 _____ Age 18 to 35
_____ Age 36 to 50 _____ Age 51 to 65 _____ Over 65 years old
10. Is medical equipment supplied or are your personnel responsible for monitoring any equipment? No Yes
If "Yes," describe all such equipment: _____

11. Provide details for licensing or certification needed for this operation: _____

12. How long have you been licensed/certified? _____
13. Has your license ever been suspended or revoked? No Yes
If "Yes," explain: _____

14. Your premium is adjustable based on your total receipts. Our auditor will verify your total receipts. If this information is kept by your accountant, provide the accountants name, address and phone number: _____

If this information is kept by you, provide the telephone number and address where the records are kept: _____

15. Additional Comments or Intererests: _____

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?			<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: 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 _____ (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 _____	

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:

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