



ROBERT A. SCHNEIDER AGENCY, INC.

Minnesota
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 Minnetonka, MN 55343-9611
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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: | <input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Non-Profit <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) |
|---|-----------------|-------------------|-------------------------------------|--|--|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| Are any physicians to be covered under this applicant's policy? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| If "Yes", describe and submit brochure or detailed narrative of activities. | | | |
| Are there any swimming or boating activities? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Is pool or spa fenced with a self-locking gate? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Diving board or slide? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Trampoline? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Other recreation equipment (i.e. Climbing Walls)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Describe: | | | |

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, 7130 Glen Forest Drive, Richmond, VA 23226.

Applicant's Name: _____

Signature _____

Title: _____

Date: _____
