



James River Insurance Company
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ALLIED HEALTHCARE GENERAL APPLICATION

APPLICANT'S 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"/> No <input type="checkbox"/> Yes
<i>If yes, complete the following:</i>			
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	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? No Yes
 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? No Yes
 Has any applicant ever been cancelled or non renewed in the past three years? No Yes
 Any discontinued operations or programs? No Yes
If yes, explain _____
 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
 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, Employed	Has Malpractice Insurance	Limits of Liability Carried
				<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ \$
				<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ \$
Any physicians to be covered under this applicant's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes

Medication Administration:	
Are any drugs or medications administered or prescribed?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, explain</i> _____	
Who is responsible for administering medications: licensed staff <input type="checkbox"/> medication aide <input type="checkbox"/>	
How are drugs stored? _____	
Is the unitdose medication system used by the facility?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If no, what system is in use?</i> _____	

Is electroshock therapy utilized?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, explain</i> _____	

Schedule of Location: <i>If more than 3 locations, attach a separate sheet of locations</i>	
#1 Address	
Type of Services Provided	
#2 Address	
Type of Services Provided	
#3 Address	
Type of Services Provided	

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 hours		IV Therapy	
Professional hours		Other (specify):	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<i>If yes, describe and submit brochure or detailed narrative of activities.</i>			
Are there any swimming or boating activities? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Is pool or spa 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			

Check the coverages and limits that the applicant would like quoted.		
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional
Limits Requested:	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2
		<input type="checkbox"/> 500/500
		<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"/> 250/250	<input type="checkbox"/> 500/500
		<input type="checkbox"/> 100/300
		<input type="checkbox"/> Other
Higher Abuse limits may be available for select risks.		

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 _____

Title _____

Date _____