BENCHMARK MANAGEMENT GROUP
SPECIALTY LINES UNDERWRITERS

ALLIED MEDICAL GROUP HOME (NON-ELDERLY RESIDENTS) SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

For NURSING HOMES, please see the Allied Medical Asst. Living Facility (Elderly Residents) application.

APPLICANT NAME:	
LOCATION NUMBER:	
LOCATION ADDRESS:	

Number of licensed beds		Number of occupied beds	
Range of client ages? _____	How many male?_____	How many female?_____	

Patient Census	**# Ambulatory**	**Ambulatory w/Assistance**	**# Non-Ambulatory**
Severely/Profoundly Intellectually disabled			
Mild/Moderately Intellectually disabled			
Psychotic or Sociopath			
Schizophrenic			
Drug or alcohol rehab			
Emotionally disturbed/depressed			
Other (specify)			
What precautions are taken to keep track of patients?			

Sign out procedures?	☐ No ☐ Yes
Alarms on doors to prevent clients from wandering from the residence?	☐ No ☐ Yes
Is the insured a: ☐ Building Owner ☐ Tenant ☐ General Lessee	

Construction of building:		Square feet:	
Year built/updated		Number of floors	
Age of wiring/update		Number of fire extinguishers	
Number of fire escapes		Is the building sprinklered?	☐ No ☐ Yes
Do all bedrooms/hallways have smoke detectors?	☐ No ☐ Yes	Electronic or Battery operated detectors?	
Local fire alarm?	☐ No ☐ Yes	Central station fire alarm?	☐ No ☐ Yes
Are handrails provided in hallways and bathrooms?	☐ No ☐ Yes	Distance to the nearest fire station	

Are there any firearms on the premises? ☐ No ☐ Yes
If so, please describe:_____
_____

Are the firearms locked in a secure place away from the residents? ☐ No ☐ Yes
If not, please describe:_____
_____

# of Staff	**1st Shift**	**2nd Shift**	**3rd Shift**	**Staff**	**1st Shift**	**2nd Shift**	**3rd Shift**
MD				General Caregiver			
RN				Psychiatrists			
LPN				Counselor			
Nurse Aids				Speech Therapists:			
				Physical Therapists:			
Psychologists				Other (specify)			

Are Psych./MD:	☐ employees or ☐ Independent Contractors
Do any residents attend school/workshops?	☐ No ☐ Yes-number:_____
Do any residents work full or part time?	☐ No ☐ Yes-number:_____

STATE INSPECTION:

Date of last State Inspection/Survey: _____
Total # of Deficiencies: _____
Number of D, E & F Deficiencies (Nursing Homes only): _____
Number of G, H & J Deficiencies (Nursing Homes only): _____
Corrective Action Plan accepted by State: ☐ No ☐ Yes
Date accepted: _____
Number of complaints investigated by State the past 2 years: _____
Number of substantiated complaints: _____

Please attach complete details about programs offered.

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

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 COMPLETE THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.