



ALLIED MEDICAL ADULT DAYCARE SUPPLEMENTAL APPLICATION
 SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

Hours of operation: _____

1. Number of attendees (licensed) _____ Number of attendees (average attendance) _____
2. Are you currently licensed for operation by the proper regulatory authorities? No Yes
3. Is the license conditional? No Yes
 If "Yes," please explain: _____

Attendees	Number of:
Seriously mentally impaired (Alzheimer's)	
Somewhat mentally impaired (Senile)	
Aged by mentally & physically fully functional	
Developmentally Disabled	mild _____ moderate _____ profound _____
Non-Ambulatory	wheelchair-bound _____
Mentally Ill/Disabled	
AIDS/HIV	
Other (describe)	
Ages of clients: <input type="checkbox"/> under 18 <input type="checkbox"/> 18-35 yrs. old <input type="checkbox"/> 36-50 yrs. old <input type="checkbox"/> 51-65yrs. old <input type="checkbox"/> over 65	

4. What precautions are taken to keep track of patients? _____
5. Sign out procedures? No Yes
6. Alarms on doors to prevent clients from wandering from residence? No Yes
 Elopements in past three years (provide details): _____
7. Are any medications administered? No Yes
 If "Yes," please describe: _____
8. Is the insured a: Building Owner Tenant General Lessee
9. Construction of building: _____
10. Year built: _____ / _____ / _____ Number of floors _____
11. Age and type of wiring: _____
12. Number of fire extinguishers: _____ Is the building sprinklered? No Yes
13. Smoke detectors? No Yes
14. Local or Central station fire alarm?

#Staff	Number	#Staff	Number
RN		Psychologists	
LPN		Therapists	
Nurse Aids		Counselors/Social Workers	
MD		Other (describe)	

* 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.