



**ALLIED MEDICAL  
RESIDENTIAL CARE FACILITY RENEWAL APPLICATION**

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"/> In-Patient -Psychiatric <input type="checkbox"/> Other: _____		

During the last 12 months,

1. Has the number of licensed beds increased or decreased in the last year?  Yes  No  
 If "Yes," then please explain. \_\_\_\_\_
2. Please provide a copy of your current license.
3. Please provide the number of bedridden residents: \_\_\_\_\_
4. Please provide the number of Alzheimer's or dementia residents: \_\_\_\_\_
5. Have there been any elopements?  Yes  No  
 If so, how many? \_\_\_\_\_; What protocols have been put into place to prevent future elopements? \_\_\_\_\_  
 \_\_\_\_\_
6. Estimated receipts/operating budget for the next 12 months \$ \_\_\_\_\_  
 Estimated payroll for the next 12 months \$ \_\_\_\_\_
7. Has the insured's area of operations changed in the last year?  Yes  No  
 If "Yes," then please explain. \_\_\_\_\_  
 \_\_\_\_\_
8. Has the number of staff on each shift changed from last year?  Yes  No  
 If "Yes," then please explain. \_\_\_\_\_  
 \_\_\_\_\_
9. Has the facility been inspected?  Yes  No  
 If so, did it result in any deficiencies?  Yes  No  
 If "Yes," then please explain and forward a copy of the inspection along with the list of deficiencies and plan of correction. \_\_\_\_\_  
 \_\_\_\_\_

10. Have there been any claims, or incidents that could result in a claim, reported to you within the last 12 months that haven't been reported to us?  Yes  No  
If "Yes," then please explain. \_\_\_\_\_  
\_\_\_\_\_

11. Have any acts resulted in disciplinary action through any federal, state or local governmental agency?  
If "Yes," then please provide all the details.

**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 and dated to be considered for quotation.**

\* 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