Boston Insurance Brokerage, Inc.
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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: ☐ Corporation ☐ Individual ☐ Partnership ☐ Municipality ☐ For Profit ☐ Joint Venture ☐ In-Patient -Psychiatric ☐ 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? If "Yes," then please explain. ☐ Yes ☐ No _____

_____

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