COLONY SPECIALTY

Member Argo Group

ALLIED MEDICAL
NON-RESIDENTIAL CARE FACILITY RENEWAL APPLICATION

APPLICANT NAME:	Beginning Experience International Ministry, Inc.		
MAILING ADDRESS:	1657 Commerce Dr., #2B		
CITY, STATE, ZIP:	South Bend, IN 46628		
COUNTY:	St. Joseph	PHONE NUMBER:	574-283-0279
INSPECTION CONTACT:	Kathleen Murphy	DATE ESTABLISHED:	1974
YEARS IN BUSINESS UNDER CURRENT MGMT:	11.5		

Type of Enterprise: ■ Corporation ☐ Individual ☐ Partnership ☐ Municipality ☐ For Profit ☐ Joint Venture ☐ In-Patient -Psychiatric ■ Other: Not for Profit

In the past 12 months,

1. Has the insured's area of operations changed in the last year? ☐ Yes ■ No
   If "Yes," then please explain._____
2. Has the number of staff changed from last year? ☐ Yes ■ No
   If "Yes," then please explain._____
3. Has the facility been inspected and resulted 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._____
4. 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._____
5. Have any acts resulted in disciplinary action through any federal, state or local governmental agency? If "Yes," then please provide all the details ☐ Yes ■ No
   _____
6. Gross revenue and payroll for the past 12 months $159,685/$75,000
7. Gross estimated revenue and payroll for the next 12 months $200,000/$85,000
8. A copy of your most current State License NA

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.

Kathleen Murphy
Applicant's Signature

_____
Sub-Producer

Executive Director/2-15-2013
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

ARGO PRO
Member Argo Group

ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Desired Effective Date: April 1, 2014
2. Applicant Name: Beginning Experience International Ministry, Inc.
3. Mailing Address: 1657 Commerce Dr., Ste. 2B
4. City, State, Zip: South Bend, IN 46628
5. County: St. Joseph
6. Telephone Number: 574-283-0279
7. Inspection Contact: Kathleen Murphy
8. Website Address: www.beginningexperience.org
9. Date Established: 1974
10. Years in Business Under Current Management: 11.5
11. Type of Enterprise: ☑ Corporation ☐ Individual ☐ Partnership ☐ Joint Venture ☐ Municipality ☐ In-Patient -Psychiatric ☐ Other (describe):
12. Enterprise is: ☐ For Profit ☑ Not For Profit
13. Estimated receipts/operating budget for the next twelve (12) months: $200,000
14. Estimated payroll for the next twelve (12) months: $75,000
15. Type of Operation: ☐ Mental Health Inpatient ☐ Group Home (Non-Elderly) ☐ Prison/Jail ☐ Boot Camp ☐ Lock-down Facility ☐ Shelters/Halfway House ☐ Alcohol/Drug Detox. ☐ Alcohol/Drug Inpatient ☐ Apartments ☐ Foster Care (children) ☐ Independent Living (Elderly) ☐ Assisted Living Facility ☑ Other (describe): Peer grief resolution ministry
16. Full description of services rendered: Structured weekend and weekly support programs for separated, divorced and widowed persons and children of same; related training, social and fund raising activities.

II. CURRENT INSURANCE

This section must be completed for prior acts consideration. Attach a copy of expiring policy declarations page.

1. a. Has Applicant had previous insurance for this enterprise? ☑ Yes ☐ No

   b. If Yes, complete the following for prior three (3) years of general/professional liability coverage:

Name of Carrier	Effective Date	Expiration Date	Limit	Deductible	Premium	Claims Made (CM) or Occurrence?	CM Retroactive Date
Colony	4-1-12	3-31-12	1M/3M	$2,500	$12,250	Occurrence	
Colony	4-1-11	3-31-11	1M/3M	$2,500	$12,250	Occurrence	
Colony	4-1-10	3-31-10	1M/3M	$2,500	$12,250	Occurrence	

III. CLAIMS ACTIVITY AND INCIDENT REPORTING PROCEDURES

1. Claims and Incident Activity

Important Notice: All known claims and/or incidents that could reasonably result in a claim are specifically excluded from coverage. Report all such claims or incidents to your current insurer. Your failure to disclose any claim, or incident that could reasonably result in a claim, may result in the proposed insurance being void and/or subject to rescission.

a. Claims Activity - Please list all claims that have been presented to you or to your past or your current insurer during the past five years. Please continue on a separate sheet of paper if necessary.

Date of Loss	Current Reserve or Paid Amount	Description of Loss	Insurer

b. Incident Activity - Please outline the details below regarding any of the following incidents that have taken place at any of your facilities for which coverage is being requested, but where such incidents have not been reported to any insurer:

- Death of a client, patient or resident from other than natural causes;
- Injury to a client, patient or resident that required hospitalization;
- Incident involving abuse, molestation, sexual assault, rape or improper contact;
- Incident that generated a formal complaint or notice from any federal or state regulatory body;
- Injury resulting from an elopement or unauthorized absence of a client, patient or resident;
- Improper medication or improper dosage resulting in hospitalization; or
- Decubitus ulcer(s) first acquired under your care that have reached Stage IV.

1) Are there any other known incidents that could reasonably be expected to result in a claim against the Applicant? ☐ Yes ☑ No

2) Have all known incidents that could reasonably be expected to result in a claim been reported to your current or prior insurer? ☑ Yes ☐ No

2. Risk Management Protocols

a. Are there procedures in place requiring the documentation of all incidents in a written report? ☑ Yes ☐ No

b. Who is responsible for receiving and recording information relating to incidents and reporting them to your insurer?

Name: Kathleen Murphy Title: Executive Director

3. Other

a. Has any license or accreditation ever been suspended, denied or revoked? ☐ Yes ☑ No

b. Please list all professional association(s) in which the Applicant is a member in good standing:

c. Has the Applicant ever had its professional liability insurance policy cancelled or non-renewed? ☐ Yes ☑ No

d. If Yes, please explain:

IV. OPERATIONS

1. Indicate current staffing levels:

Staff	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
Administrators	1			
MD/Physicians				
Nurses				
Homemakers/Nurse Aids				
Psychologists				
Counselors				
Therapists				
Students or volunteers				1,438
Other (describe):_____		Office Staff 2		

2. Check the hiring procedures that apply or are performed by this operation:

☑ Criminal Background Checks ☑ Verification of certification or professional licensing

☐ Drug, alcohol and sexual abuse screening or testing ☑ Reference Checks

☐ Questioning of employees in their previous involvement as defendants in professional malpractice litigation

3. **Schedule of Physicians** – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
NA					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

4. List the duties of the physician(s) in 3. above:

5. Do you want any listed physician to be covered under the facility's policy? ☐ Yes ☐ No

6. a. Are any drugs or medications administered or prescribed? ☐ Yes ☑ No

b. If Yes, please explain:

V. LOCATION INFORMATION

1. **Schedule of Locations:** If more than five locations, please attach a separate sheet of locations.

	Address	Types of Services Provided
# 1	1657 Commerce Drive #2B, South Bend, IN 46628	Grief ministry support services
# 2	See attached	
# 3		
# 4		
# 5		

2. a. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? ☐ Yes ☑ No
   b. If Yes, please submit brochure or describe activities: _____

3. a. Are there any firearms on the premises? ☐ Yes ☑ No
   b. If Yes, please describe: _____
   c. Are the firearms locked in a secure place away from the residents? ☐ Yes ☐ No
   d. If No, please describe: _____

4. a. Are there any animal exposures on the premises? ☐ Yes ☑ No
   b. If Yes, are the animal exposures: ☐ Owned? ☐ Non-owned?
   c. If Yes, please describe, including number of animals and type/breed: _____

5. a. Are there any lakes, ponds, rivers, pools or other bodies of water on the premises? ☐ Yes ☑ No
   b. If Yes, please describe: _____
   c. Are there any swimming or boating activities? ☐ Yes ☐ No
   d. If there is a pool or body of water, then is it fenced with a self-locking gate? ☐ Yes ☐ No
   e. If there is a pool or body of water, then is there a diving board and/or slide? ☐ Yes ☐ No

VI. COVERAGE REQUESTED

1. Complete and attach the appropriate supplemental application with your submission.
2. Check the coverages and limits that the Applicant would like quoted:
   a. Coverages: ☑ GL ☑ Professional ☐ Excess (Attach Acord App)
   b. Limits: ☐ $100,000/$100,000 ☐ $300,000/$300,000 ☐ $500,000/$500,000
      ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☑ $1,000,000/$3,000,000
3. a. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? ☑ Yes ☐ No
   b. If Yes, at what limits? ☐ $25,000/$50,000 ☑ $50,000/$100,000 ☐ $100,000/$300,000
      ☐ $250,000/$250,000 ☐ $500,000/$500,000 ☐ Other: _____

Please attach a copy of the following with your submission:

- Five (5) years of currently dated loss runs (if in business less than five (5) years, please attach a resume of the owner/director) .
- Brochure(s) available or other information pertaining to the 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

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

Kathleen Murphy

Authorized Signature on behalf of Applicant

Sub-Producer

Executive Director - Feb. 15, 2013

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.

ARGO PRO

Member Argo Group

ALLIED MEDICAL COUNSELORS & COUNSELING SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Are you in private practice? ☑ No ☐ Yes

   Please indicate the (%) percent of time spent in the following work locations:

Administrative Office	____	Patient's Home	____	Professional Office	____
Classroom	____	Outpatient Clinic	____	Laboratory	____
Operating Room	____	Nursing Home	____	Emergency Dept.	____
Hospital Ward (specify)	____	Other (specify)	____	of a Hospital	

2. If services performed are counseling, indicate the (%) percent of total counseling:

Family Planning	____	Drug Methadone	____	Legal	____	Crisis Intervention	____
Marital	____	Alcohol	____	Criminal	____	Adoption Screening	____
Family	____	Narcotics	____	V.D.	____	Foster Care Screening	____
Abortion	____	Domestic Abuses	____	Pastoral	____	Other (specify)	____

3. Please provide the percentage of counseling work performed for each of the following age brackets (should equal 100%): Ages: 0-12 _____ 13-18_____ 19-34 _____ 35 and up_____

4. Please answer the following:

   a. Are you a religiously affiliated or pastoral counselor? Organization ☐ No ☑ Yes
   b. Number of families in church? ☐ No ☐ Yes
   c. Is there a charge for counseling services? ☐ No ☐ Yes
   d. Are counseling sessions kept strictly confidential? ☐ No ☐ Yes
   e. If "No," explain:_____
   f. Any youth group activities? ☐ No ☑ Yes
   g. Any overnight activities? ☐ No ☑ Yes
   h. If "Yes," please describe: Weekend grief resolution programs held at various retreat centers
   i. Who supervises? Trained volunteer
   j. How many supervisors?_____
   k. Day Care? ☑ No ☐ Yes

      If "Yes," number of children, number of staff, hours of operation:_____

5.

EMPLOYEES	NUMBER OF FULL TIME	NUMBER OF PART TIME
Administrators*	1 - MBA	0
Counselors*	0	0
Psychologists	0	0
Nurses,RN	0	0
Nurses, LPN	0	0
*Indicate Total with Masters		
DEGREE	**FULL TIME**	**PART TIME**
Home Health Aids	0	0
Social Workers	0	0
Clerical	0	0
Teachers	0	0
Physicians	0	0
Minister/Priest/Rabbi	0	0
Psychiatrists	0	0

6. Estimated number of outpatient visits in the next 12 months: NA
   Estimated number of outpatient visits in the previous 12 months: NA
   Estimated number of Hot Line Calls in the previous 12 months: NA

7. Is applicant engaged in, associated with, or involved in any other enterprise? ☑ No ☐ Yes
   If "Yes," provide details: _____

8. List any professional association in which applicant is a member: National Association of Catholic Family Life Ministers

9. Describe any professional training, licensing or certification needed for this operation: _____
   In house training program for all volunteers, Virtus training for volunteers in youth programs

10. Is anyone applying for insurance under this policy aware of any circumstances involving sex with any patients, former patients or relatives thereof? ☑ No ☐ Yes
    If "Yes," please explain: _____

11. Does anyone applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? ☑ No ☐ Yes
    If "Yes," please explain: _____

12. Does anyone applying for insurance under this policy use any form of recovered or repressed memory therapy? ☑ No ☐ Yes
    If "Yes," please explain: _____

13. Does anyone applying for insurance under this policy testify or consult in child abuse litigation (civil or criminal)? ☑ No ☐ Yes
    If "Yes," please explain: _____

14. Do you administer any anesthesia? ☑ No ☐ Yes
    If "Yes," please explain: _____

15. Do you prescribe medications? ☑ No ☐ Yes
    If "Yes," please explain: _____

16. If you contract your services to others on an independent contractor basis, advise who you contract your work to: _____

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_____ Sub-Producer

Executive Director/Feb.15, 2013
Title/Date

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ARGO-PRO

Member Argo Group

ALLIED MEDICAL HIRED & NON-OWNED AUTO SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Number of owned autos 0
2. Do you have auto liability coverage for owned autos? ☐ No ☐ Yes
3. Is Hired and Non-Owned auto liability covered under the owned auto policy? ☐ No ☐ Yes

COMPLETE IF HIRED AUTO COVERAGE IS DESIRED:

4. Do any of your agents, independent contractors, or employees lease autos in your name? ☑ No ☐ Yes
   If "Yes, explain:_____
5. Types of autos hired:_____
6. What is passenger capacity of hired autos?_____
7. Are any hired autos leased? ☐ No ☐ Yes
   What are the average terms of the lease? _____
8. Are the same autos leased or does it vary? ☐ Same Autos ☐ Varies
   If the same, explain why the autos cannot be scheduled on the policy. _____
9. Do you provide drivers to operate hired autos? ☐ No ☐ Yes
   If "No," will the drivers be required to provide a Certificate of Insurance? ☐ No ☐ Yes
   What are the *minimum* liability limits required by the lessee (you)?_____
10. Is there a written lease agreement? If "Yes," attach a copy. ☐ No ☐ Yes
11. Will you be named as an additional insured on the lessor's policy? ☐ No ☐ Yes
12. Do you lease, hire, rent or borrow any auto (other than a private passenger type auto) owned or leased by your employees, partners, or members of their household? ☐ No ☐ Yes
    If "Yes," give details and how many._____
13. Do you own or control any subsidiary or are you affiliated with any other corporation? ☐ No ☐ Yes
    If "Yes," what is the business or affiliate?_____
14. Do you understand that we may audit your records regarding the cost of hire? ☐ No ☐ Yes

COMPLETE IF NON-OWNED AUTO COVERAGE IS DESIRED:

15. Why is non-ownership liability coverage being requested?_____
    Employees occasionally use personal autos for ministry business
16. What types on non-owned autos will be used in your business? Passenger vehicles

NON-OWNED AUTO COVERAGE (continued):

17. How will they be used? Errands, travel to meetings, visit volunteer groups

18. What is the maximum distance which a non-owned auto may be driven from your premises? 500 miles

19. Total number of non-owned autos used in your business 3

20. What percentage of your business involves client transportation? 0 %

21. Do you have any emergency transportation of your clients? ☑ No ☐ Yes

22. Total number of employees 3

23. How often are non-owned autos used in your business?
    Daily____ Weekly____ Monthly x
    Estimate number of hours used:
    Daily____ Weekly____ Monthly 5

24. Do your employees lease autos on your behalf? ☑ No ☐ Yes

25. What is the estimated annual mileage for use on all non-owned autos? ____ miles

26. Do you require employees to have their own insurance? ☐ No ☑ Yes
    If "Yes," what are the minimum limits required? ____

27. Do you require evidence of insurance? ☑ No ☐ Yes

28. Do you check MVR's annually? ☑ No ☐ Yes

29. Will you use non-owned autos other than those owned by your employees? ☐ No ☑ Yes
    If "Yes," describe relationship: Occasional rental car

30. If a Social Service operation:
    Indicate total number of volunteers furnishing autos in your operation ____
    Maximum number of volunteers at any one time ____

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Kathleen Murphy
Applicant's Signature

Sub-Producer

Executive Director/Feb. 15. 2013
Title/Date

Producer

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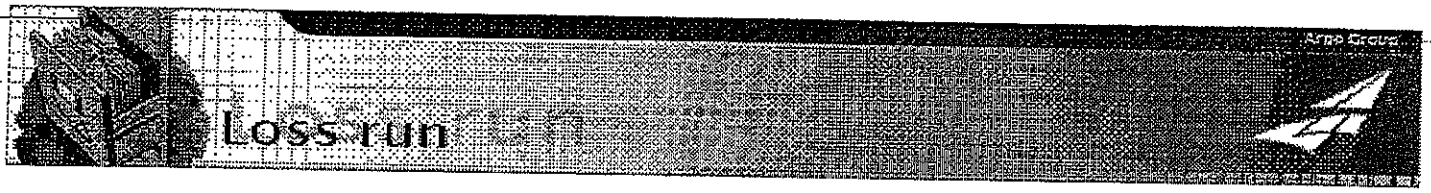

Insured Name | Policy number

or MP671701 Go Back Reset Print Save as PDF

◉ Current ○ History (before 10/1/98)

As of: 1/20/2012

Policy

Name insured:	CRESCENT ROAD LLC		
Policy #:	MP671701	Company name:	COLONY INSURANCE COMPANY
Agent name:	BLISS & GLENNON MIDWEST	Source	C

Claims

Policy period: **4/2/2010 - 4/2/2011**

No claims

Policy period: **4/2/2011 - 4/2/2012**

No claims

Beginning Experience International Ministry, Inc.

Date: Feb. 15, 2013

# of locations	Beginning Experience Location North America	State	Country	Number of Volunteer	Number of empoyees
1	Sarnia	ON	Canada	31	0
1	Winnipeg	MB	Canada	30	0
1	Albuquerque	NM	USA	14	0
1	Alexandria	LA	USA	32	0
1	Baton Rouge	LA	USA	7	0
1	Birmingham	LA	USA	44	0
1	Central Minnesota	MN	USA	46	0
1	Cincinnati	OH	USA	37	0
1	Connecticut	CT	USA	6	0
1	Dallas/Ft. Worth	TX	USA	20	0
1	Des Moines	IA	USA	35	0
1	Detroit	MI	USA	20	0
1	Eastern North Dakota	ND	USA	74	0
1	Eastern South Dakota	SD	USA	54	0
1	Eastern Tennessee	TN	USA	6	0
1	Grand Rapids	MI	USA	22	0
1	Greater Kansas City	KS	USA	31	0
1	Harrisburg	PA	USA	12	0
1	Hawaii	HI	USA	15	0
1	Houston	TX	USA	16	0
1	Hudson Valley	NY	USA	30	0
1	Huntsville	AL	USA	11	0
1	Las Cruces	NM	USA	3	0
1	Long Island	NY	USA	21	0
1	Lowcountry South Carolina	SC	USA	27	0
1	Marshall/Southwest Minnesota	MN	USA	34	0
1	Midwest BBE	IN	USA	8	0
1	New Orleans	LA	USA	21	0
1	Northwest Iowa	IA	USA	32	0
1	Oklahoma City	OK	USA	42	0
1	Omaha	NE	USA	35	0
1	Orange County	CA	USA	12	0
1	Oregon	OR	USA	15	0
1	Phoenix	AZ	USA	41	0
1	Pittsburgh	PA	USA	23	0
1	Rochester	MN	USA	35	0
1	Rochester	NY	USA	42	0
1	Sacramento	CA	USA	61	0
1	San Angelo	TX	USA	22	0
1	San Antonio	TX	USA	27	0
1	San Diego	CA	USA	27	0
1	San Jose	CA	USA	15	0
1	Spokane	WA	USA	10	0
1	Springfield	MO	USA	28	0
1	Tacoma	WA	USA	18	0
1	Tulsa	OK	USA	21	0
1	Western North Dakota	ND	USA	108	0
1	Western North Dakota CBE	ND	USA	42	0
1	Wichita	KS	USA	21	0
1	Wichita YABE	KS	USA	25	0
1	Wyoming	WY	USA	29	0
51	**Total US and Canada**			**1,438**	**0**

# of locations	Name of Beginning Experience Team Overseas	Country	Number of Volunteers	Number of empoyees
1	Hexham and Newcastle YPBE	England	11	0
1	Hexham/Newcastle	England	24	0
1	Kent	England	16	0
1	London, England	England	5	0
1	Cork	Ireland	30	0
1	Dublin	Ireland	75	0
1	Dundalk	Ireland	18	0
1	West of Ireland	Ireland	47	0
1	Belfast	Northern Ireland	16	0
1	Scotland	Scotland	14	0
10	**Total Britain and Ireland**		**256**	**0**
1	Brisbane	Australia	23	0
1	Lismore	Australia	20	0
1	Perth	Australia	33	0
1	Broken Bay	Australia	6	0
1	Auckland	New Zealand	31	0
1	Wellington	New Zealand	5	0
1	Singapore	Singapore	96	0
7	**Total Asia Pacific**		**214**	**0**
17	**Grand total volunteers**		**1,908**	**0**

These Locaitons found it necessary to close

Reason: Insufficient new volunteers to continue the ministry

Dubuque, Iowa

Trenton, NJ

Kent, England

New Locations

Eastern Tennessee

Estimated Annual Revenue FY 2013-2014 = $200,000

Does NOT include Current Reserve $107,997

Estimated Annual Expense FY 2011-2012 = $207,000

(Includes payroll expense $70,000)

Employees:

1 Executive Director - full time

2 Office staff - part time