

GENERAL INFORMATION

Insured Name _____

Address _____

Telephone _____ Agent _____

Agency Address _____

Telephone _____ Fax _____ E-mail _____

Policy Effective Date _____

1. How long has the insured been in business? _____

(Attach copies of latest annual report and balance sheet)

2. Is the insured a non-profit corporation? Yes No

If No, describe _____

3. Insured Website _____

4. Name of director _____

5. Business manager _____

6. Annual budget _____ Fiscal year _____

7. Describe the insured's funding _____

8. How is the insured's facility licensed? _____ (Attach copies of all licenses)

9. Describe the operations _____

10. Lines of business submitted? (Please submit all ACORD applications below where applicable)

Package Auto Umbrella Professional D & O

11. Include the following items:

A) Loss runs for past 5 years

B) Hiring and screening practices

C) Financial Statements

D) Brochures

12. Has any insurer cancelled, declined, or refused renewal? Yes No

If yes, why? _____

13. Has any license ever been suspended or revoked? Yes No

If Yes, explain: _____

14. Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines?

Yes No If Yes, explain: _____

15. Is applicant accredited by:

JCAHO CARF COA Other: _____

16. List all association memberships or affiliations: _____

Please complete both below Parts I & II of the application.

Part I **Social Services**

Part II **Professional Liability** (If coverage is required for Physicians/Psychiatrists, complete "Attachment A")

Attachment A) Physician Information Sheet

Attachment B) Professional Liability (Claims-Made Supplement)

PART I SOCIAL SERVICES

Section 1) Premises/Operations Information

A) Facility operated by Applicant: Owned by Applicant Leased by Applicant

If owned does Applicant lease out any portion of the facility to tenants? Yes No

If Yes, describe occupancy of the tenants, including type of operations: _____

If Yes, are tenants required to carry liability insurance for their occupancy? Yes No

If Yes, what is the minimum liability limit Applicant requires of the tenant? \$ _____

Is Applicant always added as an Additional Insured to the tenant's liability policy? Yes No

Built in: _____ Square Footage: _____ Sq. Ft. Total Number Floors: _____

Construction of building: Frame Brick Non-Combustible Fire Resistive

Does Applicant provide transportation to Clients? Yes No

B) Protective Devices/Safety Information

Automatic Sprinklers Yes No

Heat Sensors Yes No

Smoke Detectors Yes No

If Yes, does each room and hallway have a smoke detector? Yes No

If Yes, smoke detectors are Electronic Battery Operated

Fire Extinguishers Yes No If Yes, how many on the premises? _____

Fire Escape Yes No If Yes, how many on the premises? _____

Fire Alarms Yes No If Yes: Central Station Local Alarm None

Distance to nearest fire station? _____ Distance to nearest fire hydrant? _____

Does Applicant have a written emergency evacuation plan? Yes No

Are there sign in/sign out procedures in place for Clients Staff Visitors

Type of security provided for the protection of your clients? Guards Video surveillance Other _____

Are there procedures to monitor client/staff activities? Yes No

What preventive measures are taken to avoid clients from entering non-permitted areas of the facility?

Does insured have procedures for staff to report any incidents including meetings to discuss such incidents to safeguard location Yes No

C) Swimming Pools

Does the Applicant utilize swimming facilities? Yes No

If Yes: On Premises Off Premises Minimum age allowed in water: _____

If No, does Applicant anticipate using swimming facilities in the future? Yes No

If Yes, Explain _____

Are pools used exclusively for Clients? Yes No

If No, Explain _____

Does the pool have a diving board? Yes No Does the pool have a slide? Yes No

Are pool depths marked? Yes No Is the pool area fenced? Yes No

Is there a self-locking gate? Yes No Is supervision adequate? Yes No

Are Lifeguards on duty at all times when Clients are using the pools? Yes No

Are all Lifeguards certified? Yes No

Is the walking surface around pool in good condition? Yes No

D) Contractors Liability

Does the Applicant contemplate any construction activity in the next year? Yes No

If Yes, describe planned construction activity and estimated contract costs: _____

E) Products/Completed Operations

Does the Applicant sell goods or services to members of the public (other than to Clients) Yes No

Types of Products: _____

Annual Receipts: \$ _____

Types of Services: _____

Annual Receipts: \$ _____

Section 2) Special Fund Raising / Sports Events Does not apply

1. Name of Applicant: _____

2. Producer: _____

3. Name of Additional Insured(s): _____

4. Their Interest: _____

5. List Date(s) of Event(s): _____

6. List Location(s) of Event(s): _____

7. Description of Event(s) (Use additional space if necessary): _____

8. Describe Security Protection: _____

9. Seating Capacity: _____ Type of Seats: _____

10. Number of Grandstands (if any): _____ Permanent: _____ or Temporary: _____

11. Estimated Attendance: _____ Ticket Price: _____

12. Estimated gross receipts: _____

13. Number of teams: _____ Number of players per team: _____

14. Number of games played: _____ Duration of season/meet: _____

15. Age range: _____ to _____ Applicants ratio of supervisors to children: _____ to _____

16. Is contractual required? Yes No (If Yes, enclose a copy of the agreement)

17. Has/Have similar events been held in the past? Yes No

18. Any alcoholic beverages being served at the event? Yes No

If yes, who is serving? _____

19. Additional Insured Interest being required? Yes No

20. Total number of events expected during the year: _____

Section 3) Sexual Misconduct Does not apply

Current Limits: _____ Occurrence / Aggregate

1. What is the age group of clients? _____

2. What is the ratio of staff to clients? _____

3. Is there more than one person responsible for the welfare of any single client? Yes No

If Yes, please describe: _____

4. Are there rules or guidelines prohibiting closed door one-on-one meetings? Yes No

If No, describe why unnecessary: _____

5. Are there written complaint procedures and are they displayed prominently? Yes No

If No, describe why unnecessary: _____

6. Do you have written formal hiring procedures? (If Yes, please submit written procedures) Yes No

a. How are employees screened? _____

b. Are at least three references secured on all prospective employees? Yes No

c. Are prospective employees checked with the Child Abuse Register and with law enforcement agencies for criminal records? Yes No

If No, please describe steps taken to ensure that these individuals are suited for job responsibilities: _____

d. Has any current employee refused to be fingerprinted and checked with law enforcement agencies?

Yes No

7. Do all employees meet the minimum mandated educational or professional experience level for the position assigned? Yes No If No, please explain: _____

8. Do volunteers work directly with clients? Yes No

(Sexual Misconduct Cont'd)

9. Have any employees been the subject of a child abuse/neglect investigation? Yes No
If Yes, what were the results of the investigation? _____
10. Have there ever been any alleged or actual incidents regarding abuse or molestation? Yes No
Please describe: _____
11. For residential risks, what steps are taken to ensure that client-to-client contact is avoided, i.e., separating male from female sleeping quarters: _____
12. Are children of different age groups housed together? Yes No
If Yes, please describe: _____
13. Are children left alone without any adult supervision? Yes No
14. List situations where an employee or volunteer has direct contact with clients in an unsupervised situation without oversight of another staff member: (you may list on a separate sheet should you require additional space for this answer) _____
15. Is any counseling conducted off premises, i.e. clients' or counselors' homes? Yes No
If yes, by whom and what type of clients? _____
16. Is any counseling provided after normal business hours? Yes No
If Yes, describe: _____
17. If transportation is provided, is there more than one adult present at all times? Yes No
18. What is your procedure on how allegations of abuse are handled? _____
19. What is your written documentation procedure on how allegations of abuse are handled? _____
20. Are accused employees removed from client care responsibilities pending outcome of investigation?
 Yes No If No, please describe: _____
21. What procedures have been instituted to prevent reoccurrences of previous events?

Section 4) Foster Care / Adoption Does not apply

1. Which Foster Care Services do you provide? (Check all that apply)

<input type="checkbox"/> Licensing of the foster family	<input type="checkbox"/> Placement decisions
<input type="checkbox"/> Foster Family recruitment, training, and supervision	<input type="checkbox"/> Case management
<input type="checkbox"/> Working with the family of origin	<input type="checkbox"/> Permanency planning
<input type="checkbox"/> Removal of the child (adolescent and youth) from the family or situation	<input type="checkbox"/> Certification of foster family
2. Number of foster placements: Last year: _____ This year: _____
3. Number of foster families currently certified: _____
4. Staff count: Case Workers: _____ Supervisory: _____ Other: _____
5. Are there written procedures to review potential foster/adoptive families? Yes No
6. Are there criminal background checks for member of foster families? Yes No
7. Total number of hours/days of training for foster families _____Hours _____Days
8. Are there follow-up visits after placement? Yes No If Yes, how often during the year?

9. Are there adoption services? Yes No If Yes, total number of expected adoptions during the year?

10. Any international adoptions? Yes No If Yes, total number of expected adoptions during the year?

11. Are there criminal background checks for member of foster families? Yes No
12. What percentage of insured's operation involve Foster Care? _____ Adoption? _____
13. Does the agency have an adequate number of staff for the foster/adoptive families and children served?
 Yes No
14. Is the staff assigned adequately trained? Yes No
15. Does the agency operate in accordance with applicable laws/regulations? Yes No

Section 5) Day Care Center / Nursery School Information Does not apply

Location Number(s): _____

1. Description of premises: _____

Private Home Commercial Building School

2. Interest: Owner Tenant

3. Describe affiliation (church, school, other): _____

4. Part occupied by applicant (i.e., basement, 1st floor, 2nd floor): _____

5. Area occupied (sq. ft. dimensions): _____

6. Construction of building: Frame Brick Non-Combustible Fire Resistive

7. Number of floors: _____ Age of building: _____ Type of heating: _____

8. Does applicant have a play area: Yes No If Yes, describe equipment and list security measures (i.e. locked gates etc) _____

9. Any "Yes" answers to the following must be described in remarks below (attach separate sheet if necessary):

	YES	No		YES	No
Pools on the premises (must be fenced)	<input type="checkbox"/>	<input type="checkbox"/>	Animals, Pets	<input type="checkbox"/>	<input type="checkbox"/>
Physically/Mentally handicapped or developmentally disabled children	<input type="checkbox"/>	<input type="checkbox"/>	Gymnastic Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Nurses, Therapists, Counselors	<input type="checkbox"/>	<input type="checkbox"/>	Unique/unusual teaching techniques	<input type="checkbox"/>	<input type="checkbox"/>
Field Trips	<input type="checkbox"/>	<input type="checkbox"/>			

Remarks: _____

10. Is applicant licensed or certified as a Day Care Center/Nursery School? Yes No

If Yes, please attach a copy of the license.

If No, explain: _____

11. Has applicant ever been cited by authorities for day care violations with or without suspension or revocation of certification or license? Yes No If Yes, explain in detail on separate sheet.

12. Does applicant require a release of liability from all children? Yes No

If no, will you institute such a program? Yes No

13. Applicant is licensed to care for children ages _____ to _____.

(If no license required, state maximum numbers)

Number children: Under age 2: _____ From 3 to 5: _____ From 6 to 10: _____ Over age 10: _____

14. Applicant's ratio of supervisors to children is _____ to _____

15. Applicant operates _____ days per week from _____ to _____. Average daily attendance of _____ children.

Section 6) Residential Care / Inpatient Care Facility Does not apply

1. Please list location numbers with residential care/inpatient facilities: _____

2. Full description of services rendered (Attach all brochures and promotional material): _____

3. Is the facility run by an outside management company? Yes No

If Yes, describe the relationship: _____

4. How long under present management? _____

5. Date established: _____

6. Indicate estimated: Receipts \$ _____ or Operating Budget \$ _____ Payroll \$ _____

7. Is the applicant engaged in, owned by, associated with, or involved in any other enterprise?

Yes No If Yes, describe: _____

8. Are you currently licensed for operation by the proper regulatory authorities? Yes No

(Attach a copy of the license.)

Is the license conditional? Yes No

If Yes, explain: _____

Has the license ever been revoked? Yes No

If Yes, explain: _____

(Residential Care Facility Cont'd)

9. TYPE OF FACILITY:

	TOTAL # OF BEDS	AGE OF RESIDENTS	M=MALE F=FEMALE OR BOTH	LENGTH OF STAY	CLIENT-STAFF RATIO
<input type="checkbox"/> Alcohol or Drug - Rehab					
<input type="checkbox"/> Alcohol or Drug - Treatment					
<input type="checkbox"/> Alcohol or Drug - Detoxification					
<input type="checkbox"/> Psychiatric Care					
<input type="checkbox"/> Shelter for runaways, abused spouses, foster children					
<input type="checkbox"/> Homeless Shelter Facility					
<input type="checkbox"/> School: (state type of school): _____					
<input type="checkbox"/> Group home - Mental/ Physical Rehab					
<input type="checkbox"/> Group home - Developmentally Disabled					
<input type="checkbox"/> Group home - Troubled Youth					
<input type="checkbox"/> Transitional Housing - Low-income					
<input type="checkbox"/> Aged - Independent living					
<input type="checkbox"/> Aged - including intermediate care					
<input type="checkbox"/> Aged - including skilled care					
<input type="checkbox"/> Hospice					
<input type="checkbox"/> Nursing home for senile or aged					
<input type="checkbox"/> Other (specify): _____					

Total number of bed for all facilities: _____ How many beds are currently occupied: _____
Is the facility (check one): Co-ed or Single Sex If Co-ed, how are patients segregated and monitored?

Are clients of different age groups segregated? Yes No Please describe: _____

Number of bedridden clients: _____

10. TYPE OF CLIENT AT ALL FACILITIES ABOVE:

	AMBULATORY	NON-AMBULATORY	TOTAL CLIENTS
Substance abuse patients - Rehab			
Substance abuse patients - Treatment			
Substance abuse patients - Detoxification			
Somewhat mentally impaired (i.e. Senile)			
Seriously mentally impaired (i.e. Alzheimer's)			
Aged but mentally and physically fully functional			
Mentally/Physically disabled requiring intermediate care			
Mentally/Physically disabled requiring skilled care			
Other (Specify): _____			

11. What floors are the non-ambulatory patients on? _____ How many patients are on each floor? _____

12. Are restraints used? Yes No If yes, attach copies of restraining procedures that are in force.

13. Other operations:

Counseling # of visits: _____

Home care # of visits: _____

Day time care # of clients: _____

Other (specify): _____

14. If counseling is provided, describe (e.g., group therapy, individual counseling): _____

15. List other types of services provided (e.g., beautician services, podiatry, dentistry): _____

Provided for: _____ By staff: _____ By Contractors: _____

(Residential Care Facility Cont'd)

16. Ages of patients: Under 18 18-35 yrs old 36-50 yrs old 51-65 yrs old Over 65
Client to Staff Ratio: _____
17. Precautions taken to keep track of patients:
Sign out procedures? Yes No
Are there alarms on doors to prevent clients from wandering from the residence? Yes No
Other: _____
Are routine bed checks performed? Yes No How often? _____
Are they logged? Yes No
18. Do any patients work full or part time jobs? Yes No
If Yes, what percentage of patients work: _____% What type of work: _____
19. Are any medications administered? Yes No
If Yes, list any medication administered and in what form given (e.g., Methadone, given in pill form): _____
20. Is the insured a: Building Owner Tenant General Lessee?
Name any other tenants on the premises: _____
21. Explain average length of stay and type of treatment, i.e., alcohol, drug, psychiatric: _____
22. Is a Registered Nurse or M.D. on duty at all times? Yes No If No, explain availability: _____
23. Do staff members carry their own professional liability insurance? Yes No Explain in Detail: _____
24. Is any facility used for detoxification (withdrawal) of drug addicts and/or alcoholics? Yes No
If Yes, Explain: _____

Section 7) Outpatient Facilities Does not apply

Location Number (s): _____

1. Outpatient Facilities/Treatment
a. Estimated number of client contacts** per year (excluding Methadone): _____ Annual Visits: _____
b. Methadone maintenance: Yes No If Yes, estimated doses administered per year: _____
c. Counseling: Yes No
2. Does insured operate a clinic? Yes No If Yes, annual number of visits: _____
3. Does the insured operate a crisis hotline? Yes No If Yes, annual # of calls received: _____
4. Do you provide any services/programs for ex-offenders? Yes No If Yes, please describe type of offenses: _____
5. Do you operate an adult day care facility and/or senior day care center? Yes No
If Yes, please answer the following:
a) Type of activities/services offered: _____
b) Total number of clients daily: _____ Annually: _____
c) Staff to client ratio: _____
6. Do you provide a meal delivery service? Yes No If Yes, annual number of meals served: _____
7. Do you offer training/vocational programs? Yes No If Yes, annual number of clients: _____
Types of programs offered: _____
8. Do you offer information or referral services to clients? Yes No If Yes, annual number of clients: _____
Types of referrals offered: _____

**CLIENT CONTACTS: For the purpose of computing the premium charge, we count the following to be a client contact, regardless of the discipline of the counselor:

- 1) Individual Counseling: Face-to-Face visit, including Outreach
- 2) Group Therapy: Each member of a group, each session
- 3) Day Care/Camps: Each client/day counts

Section 8) Sheltered Workshop **Does not apply**

Location Number (s): _____

1. Estimated number of client days per year: _____
2. Maximum number of clients any one day: _____
3. Brief description of activities and nature of products: _____

4. Estimated annual receipts: \$ _____
5. Do clients work with power equipment? Yes No
If Yes, please describe: _____
6. Is coverage for Products Liability desired? Yes No
7. How is the product sold? Wholesale Retail Jobber Direct
8. Are hold harmless agreements given to others in connection with products manufactured by applicants?
 Yes No
9. Contractual Liability: Attach copy of all contracts to be covered other than the following' lease of premises, easement agreements, side tract agreements, agreements required by municipal ordinance elevator maintenance agreement.
10. Any of the following performed:
Spray painting: Yes No
Discharge of fumes: Yes No
Discharge of acids or wastes: Yes No
Use of radioactive materials: Yes No

Describe any hazard, on or away from the premises, not normally existing with this class of business:

Section 9) Recreational Facilities / Camps **Does not apply**

Location(s): _____

Limits of Liability Requested: _____

PLEASE ANSWER ALL QUESTIONS. IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"

I) Applicant Premise Information

1. Name of Facility/Camp (if different than Applicant)
2. Dates of Camp (if applicable)
3. Is the camp accredited by A.C.A? Yes No
4. Is the camp a member of another camping association? Yes No
If yes, which one(s)? _____
5. Is the facility Co-ed Boys Girls
6. Is the facility Day Overnight Travel
7. Years in Business: _____ Under Present Management: _____
8. Please indicate which of following activities campers are involved in:

<input type="checkbox"/> Horseback riding	<input type="checkbox"/> Wilderness adventure	<input type="checkbox"/> Football	<input type="checkbox"/> Climbing wall
<input type="checkbox"/> Archery ranges	<input type="checkbox"/> Hiking	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Basketball
<input type="checkbox"/> Canoeing, boating	<input type="checkbox"/> Swimming	<input type="checkbox"/> Boxing/Wrestling	<input type="checkbox"/> Baseball/Softball
<input type="checkbox"/> Water sports (waterskiing, etc.)	<input type="checkbox"/> Waterslide	<input type="checkbox"/> Karate/Martial Arts	<input type="checkbox"/> Soccer
<input type="checkbox"/> Snow Sports (cross country skiing, snow-shoeing, etc.)	<input type="checkbox"/> Ropes course	<input type="checkbox"/> Other	
9. Please provide details (including safety controls) for all activities the clients will be involved in during the duration of their stay:

II) Premium Basis (If Applicable)

10. Estimated number of campers per day/week: _____ Annual: _____ Age range of campers: _____
11. Estimated number of days per week? _____ Weeks per Year? _____

(Camps Cont'd)

III) Underwriting Criteria

12. Total number of staff _____ Client to staff ratio? _____
13. Does the applicant have an accident & health policy? Yes No
If yes, who is the carrier, and what is the limit of liability? _____
14. Does the applicant require clients to sign waivers? Yes No
15. Any hold harmless agreements? Yes No
If yes, with whom and what is the nature of the agreement? _____
16. If overnight camp, please answer the following:
 - a) What type of cooking takes place (deep-fryers, etc.)?

 - b) What kind of fire suppression system is in the kitchen area?

 - c) Are the cabins/sleeping areas equipped with hard wired smoke detectors? Yes No
 - d) Is there a no smoking policy in place for campers/staff (or a designated smoking area)? Yes No
 - e) Are camp fires allowed, and if so, where & how are flammables stored? _____
 - f) Is there an evacuation plan in place (in case of natural disaster or forest fire)? Yes No
17. Does the facility specialize in camping experiences for physically or developmentally disabled individuals? Yes No
If yes, please provide a complete narrative of such program(s) below or on a separate sheet, if necessary: _____

Section 10) In-Home Support Services Does not apply

1. Services Provided:

<input type="checkbox"/> Nursing Care	<input type="checkbox"/> Speech therapy	<input type="checkbox"/> Bathing
<input type="checkbox"/> Changing catheters	<input type="checkbox"/> Social work	<input type="checkbox"/> Laundry
<input type="checkbox"/> Infusion therapy	<input type="checkbox"/> Nutrition counseling	<input type="checkbox"/> Meal preparation
<input type="checkbox"/> Medical management	<input type="checkbox"/> Repositioning	<input type="checkbox"/> Housework
<input type="checkbox"/> Blood testing	<input type="checkbox"/> Restroom aid	<input type="checkbox"/> Dressing
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
2. How long has the program been in place? _____
3. How many employees provide in-home services? _____ Volunteers? _____
4. How many "Nursing" visits (column #1) do you provide annually? _____
5. How many other visits (columns #2 & #3) do you provide annually? _____
6. Do you have procedures in place regarding client security? _____
7. How do you monitor in-home service providers? _____

Section 11) Employee Dishonesty Supplement **Does not apply**

GENERAL

1. Total number of employees: _____ Total number of volunteers: _____
2. Number of employees who handle money, securities or other property: _____
3. Is your operation a Non-Profit Organization? Yes No
4. What is your annual budget? _____
5. Do you expect the number of employees/volunteers to grow substantially this year? Yes No
6. Name of current insurance carrier and employee dishonesty limits: _____
7. Why are you requesting this limit? _____

LOSSES

8. List any losses during the past 5 years: (Include description and amount of loss along with remedial action taken to prevent further losses): _____
9. At the present time, do you suspect any dishonest activity in your operation? Yes No
10. Has your organization ever contacted authorities to investigate suspected dishonest acts by one of your employees? Yes No
If Yes, please explain circumstance: _____

PROTECTIVE CONTROLS

11. Is an annual audit performed by an outside C.P.A.? Yes No
12. Will there be an audit by an officer or employee who is a C.P.A.? Yes No
How often? _____ By whom? _____
13. Are audit reports given directly to the Board of Directors? Yes No
14. At what level of check amounts are countersignature required on all checks?
 \$1,000 or less \$1,001-\$2,500 \$2,501-\$5,000 Over \$5,000 All Levels
15. Does someone not making deposits or withdrawals reconcile the monthly bank statement? Yes No
16. Is inventory (example: computers and office equipment) monitored and tracked? Yes No
17. Is verification or review made on accounts receivables ledger by a staff member other than the person(s) normally working with such records? Yes No
How often? _____ By whom (position): _____
18. Do branch locations of your operation bank locally? Yes No
If Yes, are duplicate copies of monthly bank statements & deposit slips sent direct to the main office by the bank? Yes No
If Yes, are duplicate copies of monthly bank statements & deposit slips sent direct to the main office by the bank? Yes No

COMPUTER CONTROLS

19. Do you use a computer for any accounting, payroll, payment, or banking function? Yes No
If Yes, is output reconciled or audited by persons who do not prepare the input or process it? Yes No

PURCHASING OR RELATED FUNCTIONS

20. Are any employees permitted to have a financial interest in firms that supply goods or services to your organization? Yes No
21. Is there a policy prohibiting staff from accepting gifts or favors from suppliers or clients? Yes No
22. Are purchase orders used? Yes No
If Yes, are they pre-numbered and are copies made for accounting department staff? Yes No
23. Does any one person have sole authority to handle the order placement & disbursement? Yes No
24. Are suppliers' invoices matched with related purchase orders & attached to the checks for review at the time the checks are signed? Yes No
25. Are invoices cancelled or stamped "paid" after payment is made to avoid reuse? Yes No
26. Do you have a positive system to detect payment to fictitious suppliers? Yes No

AUTHORITY OF EMPLOYEES

27. List the names, positions and tenure of the employees authorized to do any of the following activities:
Sign Checks: _____
Handles Bank Deposits: _____
Approve Payroll: _____

Section 12) Auto Supplement Does not apply

1. Are patients/clients transported in vehicles? Yes No
2. Describe the type of occupants:
 - Physically Handicapped Elderly
 - Mentally Handicapped Non-Ambulatory
 - Children Other (describe): _____
3. List Safety Measures on board vehicles:
 - Is seat belt use mandatory? Yes No
 - Is there a matron on board? Yes No
 - Are there wheelchair lifts? Yes No
 - Are there wheelchair mounts within vehicle? Yes No
 - Any medical support equipment on board? Yes No
 - Any first aid equipment on board? Yes No
4. How often are vehicles used? _____ What are vehicles used for: _____
5. What is the normal radius of operation? _____
6. Is there any interstate travel? Yes No If Yes, please describe: _____
7. Are professional drivers used? Yes No
8. Do you order motor vehicle reports on all drivers? Yes No
9. Do volunteers operate vehicles? Yes No
10. How are drivers equipped to handle the specific type of occupant? _____
11. Are all drivers covered by Workers Compensation? Yes No
12. Any drivers under 25 years of age? Yes No Over 60 years of age? Yes No
13. Is a driver log maintained? Yes No
14. Are any vehicles driven by handicapped personnel? Yes No
If Yes, how are vehicles equipped? _____
15. Is there a formal maintenance program? Yes No
16. Who services vehicles? _____
17. Where are vehicles stored overnight? _____
18. Are there any owned or leased vehicles covered under a different policy? Yes No
If yes, explain: _____
19. Are employees permitted to take vehicles home? Yes No
If Yes, how often? _____
20. Are employees vehicles used? Yes No If Yes, how often? _____
21. Are volunteer vehicles used? Yes No If Yes, how often? _____
22. Does the insured obtain copies of auto policies from volunteers or employees? Yes No
23. Any vehicles rented or leased from others? Yes No
If Yes, how often? _____ With or without driver? _____
Are certificates of insurance obtained from the lessor? Yes No
What limits are required? _____

Hired / Non-owned Auto Information Does not apply

1. Any Owned Autos? Yes No
2. Number of Employees: _____ Number of Volunteers: _____
3. Do the employees or volunteers use their own vehicles on behalf of the insured? Yes No
If Yes, enter the approximate number of employees/volunteers that use their own vehicle for company business:
Never: _____ Occasionally: _____ Frequently: _____
4. How many drivers run errands using their own vehicles for company business? _____
5. How many drivers transport clients in their own vehicles for company business? _____
6. Do you obtain copies of insurance policies for volunteers and employees who use their own vehicles? Yes No
7. Are these records updated at least yearly? Yes No
8. Do you require insurance limits of at least 100/300/100? Yes No
If No, what limits do you require? _____
9. Are MVR's checked on volunteers/employees? Yes No
10. Do you have a driver safety program? Yes No
11. Are seat belts required to be worn by all occupants? Yes No
12. In order to obtain non-owned coverage, it is required for your own protection that all employees/volunteers who use their own vehicles regularly maintain personal auto limits of 100/300/100 with a copy of current insurance limits file with the non-profit. Are you willing to follow this procedure to protect the non-profit?
 Yes No

PART II STAFF PROFILE - PROFESSIONAL LIABILITY

CLAIMS MADE OCCURRENCE

If this is a claims-made policy, please indicate retro date: _____ (Complete Attachment B)

Current Limits: _____ Occurrence/Aggregate

1. Describe professional services provided: _____
2. Is the agency licensed by the state or by another regulatory agency? Yes No
If Yes, please describe: _____
3. Total client contacts per year: _____
4. Does the agency have any residential inpatient facilities? Yes No
(If you answered "Yes" to question #4, please complete residential section - Part I, Section 6)
5. Please provide the number of each type of caregiver below:

	EMPLOYED FT	EMPLOYED PT	VOLUNTEER FT	VOLUNTEER PT	INDEPENDENT CONTRACTOR
Homemaker, Home Health, Nurse's Aide, Sitter, Companion, Bereaval Therapist, Occupational Therapist, Paraprofessional Social Worker, Teacher					
LPN, Social Worker (BA), Dietician, Nutritionist, Dental Hygienist, Pharmacy Assistant, Lab Technician, Medical Tech, Radiology Tech, Certified Medical Asst.					
Counselor, RN, Social Worker (MA, MSW), Speech Pathologist, Dialysis Tech, Enterstomal Therapist, Clergy					
Medical Director, Project Director					
Pharmacist					
Physical Therapist, Respiratory Therapist, Phlebotomist, Nuclear Medicine Tech, Radiation Therapist					
Psychologist					
Nurse Practitioner, Physician Assistant, Paramedic, EMT					
Psychiatrist, Dentist (**Must complete Attachment A)					
Medical Doctor / D.O. / Podiatrist Acupuncturist (** Must complete Attachment A)					
Other (Client Contact only) Describe : _____					

Please include a STAFF PROFILE with your submission.

****Note: For professional coverage on these highlighted staff type above, each and every Psychiatrist, Medical Doctor, D.O., and Podiatrist must complete "Attachment A".**

6. Do you have any contractual agreements to provide services? Yes No
If Yes, please describe: _____

Applicant Signature/Title _____ Date _____

**ATTACHMENT A
PHYSICIAN INFORMATION SHEET**

(To be completed for each Physician, Psychiatrist, Dentist, etc.) **Does not apply**

Name of Physician: _____

Specialty: _____

License type (i.e. MD, DO, DDS, etc.) _____ State of License _____

Describe the professional services you provide on behalf of the insured: _____

How many hours per week do you work on behalf of the insured? _____

Do you perform surgery on behalf of the insured? Yes No

If Yes, explain: _____

Have you ever had a malpractice claim or suit filed against you? Yes No

If Yes, (Explain on a separate page)

Have you ever had your license revoked, suspended, or restricted? Yes No

If Yes, (Explain on a separate page)

Have you ever been?

a. The subject of an investigatory or disciplinary proceeding or reprimand? Yes No

b. Convicted of a serious violation of any law other than a traffic offense? Yes No

c. Treated for alcoholism or drug addiction? Yes No

Is your current professional policy an Individual Institution

Do you currently carry own malpractice insurance? Yes No

If "Yes", does your insurance cover you for services you perform on behalf of the insured? Yes No

(*Also if "Yes", Please attach policy declaration page)

Please provide the following information regarding your professional liability coverage:

Carrier _____

Effective Date _____

Policy Limits: \$ _____ Each Claim \$ _____ Aggregate

Retroactive Date _____ Annual Premium _____

Applicant's Signature _____ Date _____

ATTACHMENT B
PROFESSIONAL LIABILITY (CLAIMS-MADE SUPPLEMENT) **Does not apply**

1. Name of Applicant: _____
2. a) Date of first claims-made policy: _____
- b) During this period, did the applicant ever go without insurance? Yes No
If yes, explain: _____
- c) During this period, was claims made coverage provided continually with the same retro date? Yes No

List liability insurance carried for each of the past years up to the retro date.

INSURANCE COMPANY	POLICY NUMBER	LIABILITY LIMITS	DEDUCTIBLE (IF ANY)	PREMIUM	INCEPTION MO./DAY/YR	EXPIRATION MO./DAY/YR	WAS THIS A FULL CLAIMS-MADE FORM?	
							GL.	PROF.
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

IF NONE, STATE NONE.

3. Has the applicant referred a patient/client to another specialist for treatment or services which resulted in an adverse outcome that may lead to a claim or legal action? Yes No
4. Is the applicant cognizant of any fact, circumstances or situation whereby he/she might suspect valid grounds for any future claim against them? Yes No
5. Give details of any activities, services or operations that may have been performed during the prior acts period that have since been discontinued: _____

6. HAS APPLICANT HAD ANY INCIDENTS IN THE LAST FIVE YEARS THAT MAY GIVE RISE TO A CLAIM?
 Yes No If Yes, please provide details below:

	DATE OF LOSS	STATUS OPEN/CLOSED	AMOUNT RESERVED/PAID	CLAIM DESCRIPTION/ALLEGATION
1				
2				
3				
4				
5				

WARRANTY: It is warranted to the Insurance Company that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We hereby authorize the release of claim information from any prior insurer to North Island Group, Underwriting Manager for the Company.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force.

One signed copy will be attached to the policy, cover note or certificate, if issued.

* 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.

Signature/Title _____ Date _____

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or another (NY: other) person files an application for insurance (NY: or statement of claim) containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, (NY: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation) and subjects the person to criminal and civil penalties. In Maine and Virginia, insurance benefits may also be denied.

Notice to Arkansas applicants: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Notice to Colorado applicants: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies."

Notice to Florida applicants: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree."

Notice to Kentucky applicants: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

Notice to Minnesota applicants: "A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

Notice to New Jersey applicants: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

I understand that in order to underwrite professional liability insurance, the Company must have access to information concerning my personal and professional life. I hereby authorize and direct any medical society, medical professional, hospital, residency program, insurance company, underwriter, insurance agent or other entity to furnish any information concerning me or my medical practice which the Company may request. I understand that any policy issued will rely on the truth of the statements and representations I have made herein and that misrepresentations that are fraudulent, or such that the Company would not have issued the policy if the true facts had been known, may result in a denial of coverage for any claim which may be made under this insurance.

Applicants Signature/Title _____ Date _____

Broker's name and address _____ Date _____

Broker's signature _____ Date _____