

**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 Escapes  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
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)  
 Licensing of the foster family  Placement decisions  
 Foster Family recruitment, training, and supervision  Case management  
 Working with the family of origin  Permanency planning  
 Removal of the child (adolescent and youth) from the family or situation  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 involves 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, 1<sup>st</sup> floor, 2<sup>nd</sup> floor): \_\_\_\_\_  
 5. Area occupied (sq. ft. dimensions): \_\_\_\_\_  
 6. Construction of building:  Frame  Brick  Non-Combustible  Fire Resistant  
 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 (e.g. 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, 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: \_\_\_\_\_

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

	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 <b>intermediate care</b>			
Mentally/Physically disabled requiring <b>skilled care</b>			
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: \_\_\_\_\_

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:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discharge of fumes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discharge of acids or wastes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use of radioactive materials:	<input type="checkbox"/> Yes	<input type="checkbox"/> 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
- 4a. Is the camp a member of another camping association?  Yes  No
- 4b. 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? \_\_\_\_\_

**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  
 Are camp fires allowed, and if so, where & how are flammables stored? \_\_\_\_\_  
 e) \_\_\_\_\_ 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: \_\_\_\_\_

- Physically Handicapped  Elderly  
 Mentally Handicapped  Non-Ambulatory  
 Children  Other (describe): \_\_\_\_\_

Section 12) **Auto Supplement**  Does not apply

1. Are patients/clients transported in vehicles?  Yes  No
2. Describe the type of occupants:
3. List Safety Measures on board vehicles:

• Is seat belt use mandatory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Is there a matron on board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are there wheelchair lifts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are there wheelchair mounts within vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Any medical support equipment on board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Any first aid equipment on board?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 on 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					
<b>Psychiatrist, Dentist (**Must complete Attachment A)</b>					
<b>Medical Doctor / D.O. / Podiatrist Acupuncturist (** Must complete Attachment A)</b>					
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: \_\_\_\_\_

Medical 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.	

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

**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."

**Notice to Washington applicants:** "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."

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 \_\_\_\_\_