GENERAL INFORMATION

Insured Name _____
Address _____
Telephone _____ Fax _____ E-mail _____
Policy Effective Date _____

1. How long has the insured been in business? _____
2. Is the insured a non-profit corporation? ☐ Yes ☐ No
   If No, describe _____
3. Insured Website _____
4. Name of Executive Director _____
5. Business Manager _____
6. Annual budget _____ Fiscal year _____
7. Describe the insured's funding _____
8. Describe the operations _____
9. How is the insured's facility licensed? _____(Attach copies of all licenses)
10. Lines of business submitted? (**Please submit all ACORD applications below where applicable**)
    ☐ Package ☐ Auto ☐ Umbrella
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. List all association memberships or affiliations: _____

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 or provide swimming facilities? ☐ Yes ☐ No

If Yes, complete Swimming Pool supplemental application

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) **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

1. List any losses during the past 5 years: (Include description and amount of loss along with remedial action taken to prevent further losses): _____

_____

_____

2. At the present time, do you suspect any dishonest activity in your operation? ☐ Yes ☐ No
3. 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

1. Is an annual audit performed by an outside C.P.A.? ☐ Yes ☐ No
2. Will there be an audit by an officer or employee who is a C.P.A.? ☐ Yes ☐ No
   How often? _____ By whom? _____
3. Are audit reports given directly to the Board of Directors? ☐ Yes ☐ No
4. 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
5. Does someone not making deposits or withdrawals reconcile the monthly bank statement? ☐ Yes ☐ No
6. Is inventory (example: computers and office equipment) monitored and tracked? ☐ Yes ☐ No
7. 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): _____
8. 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

1. 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

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

AUTHORITY OF EMPLOYEES

1. 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 5) **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?	☐ 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? _____

Section 6) **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

Fraud Warning

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.

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 _____