

The following questionnaire must be signed and submitted for underwriting approval prior to binding coverage.

Not Acceptable in Human Services Program:

1. Foster Care
2. Nursing Home
3. Assisted Living facility for seniors
4. One-on-one mentoring – off-premises
5. Services for pedophile/sexual aggression treatment
6. Services for court-appointed juvenile justice program
7. Services for fire starters
8. Services for Violent criminal offenders
9. Home Health Care/Companion Care

PART I: GENERAL INFORMATION

1.	Insured Name:	
2.	Quote/Policy #:	
3.	Effective Date:	
4.	Number of years in operation:	Under Present Management: <input type="checkbox"/> Non-Profit <input type="checkbox"/> For-Profit
5.	Basic scope of operations (services, day care, food pantry, etc.)	
6.	Any Web site? (If yes, please provide URL): E-mail Address:	
7.	Annual operating budget: Primary funding: <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other: If Yes, explain:	Annual payroll:
8.	List all accreditations and attach copies of certificates:	
9.	List all association memberships or affiliations:	
10.	Has your license ever been suspended or revoked? If Yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART II: MANAGEMENT PRACTICES

1.	Do you have sign in/sign out procedures for: <input type="checkbox"/> Staff <input type="checkbox"/> Clients/Residents <input type="checkbox"/> Visitors/Public	
2.	Is staff required to report to the administrator all incidences that may result in a claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are written records of all incidences kept by the administrator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Are all incidences reviewed to decide which incidents get reported to the carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do you have AED(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are staff members trained to use it? <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you have a written and enforced no smoking policy? Are "no smoking" signs posted and enforced in all areas not designated for smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
7.	What type of method do you use for de-escalation? Is it approved? <input type="checkbox"/> Yes <input type="checkbox"/> No How often is the staff recertified?	

PART III: PREMISES / LIFE SAFETY

1.	If the building you occupy was built prior to 1978, has it been inspected for lead paint? If No, what is the plan for abatement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you have any plans for renovations or new construction? If Yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are any non-ambulatory patients above the first floor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Number of fire extinguishers on premises: _____ How often are they serviced?	
5.	Are all exits clearly marked in the event of a fire?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III: PREMISES / LIFE SAFETY (continued)

6.	Do you have a written emergency evacuation plan? How often are drills held?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Describe housekeeping and maintenance practices:	
8.	Describe the parking facilities: Are they well lit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Is the hot water heater set to a maximum temperature of 120 degrees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Has your facility been inspected by an insurance company or independent inspection firm? If Yes, by whom? List any deficiencies and corrective actions in the past three years:	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV: PROFESSIONAL LIABILITY

1.	Does your pre-employment background include: a. Professional references? b. Fingerprint/FBI check? c. State-level criminal background check? d. Education Verification?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	While in your employment or under contract, has any person performing professional services ever been reprimanded, suspended or disciplined by any agency or governmental entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you maintain a medication log for all dispensed medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	What is the staff turnover rate for the last 12 months?	
5.	Do you provide workers compensation for: <input type="checkbox"/> All staff members <input type="checkbox"/> Contractors <input type="checkbox"/> Consultants	
6.	Do you contract with individuals to perform professional services on behalf of your organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you obtain certificates of insurance, as evidence of medical malpractice coverage carried, for employed/contracted/volunteer medical doctors? a. What limits do you require that they carry? b. Do you confirm that coverage extends to services that MDs perform for/on behalf of your organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Does your current insurance program provide professional liability coverage? If Yes: <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made Limits: Retroactive Date: Effective dates: Carrier:	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Physicians and Psychiatrists (use additional paper as necessary):	
	Name Dr. Dr. Dr.	
	Position Degree Years in Practice License # Hours per week for insured Employed, Volunteer or Contracted? Duties for insured Any claims in past 5 years?	

PART IV: PROFESSIONAL LIABILITY (continued)

10. Staff:	POSITION	EMPLOYEES		VOLUNTEERS		CONTRACTORS		INTERNS	
		F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
		Administrator							
Counselor									
Dentist/Dental Hygienist									
Home Health Aide									
Nurse Practitioner									
Nurse – LPN									
Nurse – RN									
Nutritionist/Dietician									
Optometrist									
Pharmacist									
Physician Assistant									
Physician									
Psychiatrist									
Psychologist									
Social Worker – Bachelors (BSW)									
Social Worker – Masters (MSW)									
Teacher/Tutor/Aide									
Therapists – Occupational									
Other Positions (specify)									
Total:									

PART V: ABUSE AND MOLESTATION

1.	Total number of clients served by Insured: Residential: Non-Residential:		
2.	Does your current insurance program include Abuse and Molestation coverage? If Yes, what are the limits? <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Does your employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Do you have a written crisis plan in place if you have an incident of abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Are there written complaint procedures and are they displayed prominently? If Yes, explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises, in order to mitigate abusive relationships?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Do volunteers work directly with clients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Is there formal staff training on child/sexual abuse, including how to recognize the signs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Have any incidents resulted in an allegation of sexual abuse? Was the case settled? Was the case taken to trial? Amount paid for damages to the victim: \$ Does Insured run criminal background checks? Employees: Volunteers:	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
10.	Any one-on-one mentoring conducted off-premises?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Are criminal investigation/background checks conducted on all staff, including the owner/director and volunteers before hiring? Staff: Owner/Executive Director: Volunteers: Elaborate:	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
12.	After how many years are background checks obtained for every director, employee and volunteer?		

PART V: ABUSE AND MOLESTATION (continued)

13.	Does orientation include discussion of the following:		
	Client abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sexual abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How to recognize the signs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	What to do if a client reports someone molested her/him?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Do you require mandatory training for all staff on client abuse each year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Is there one person that employees/volunteers can report concerns confidentially?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	Are all alleged abuse incidents investigated promptly by an objective party?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Elaborate:		

PART VI: SPECIAL EVENTS/FUNDRAISING N/A

	QUESTIONS	EVENT #1	EVENT #2	EVENT #3
1.	Describe the type of event:			
2.	Total anticipated revenue:			
3.	Location of event:			
4.	Anticipated dates of the event:			
5.	Activities involved:			
6.	Number of participants.			
7.	Will alcohol be served? If yes,	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	a. Who will supply the alcohol?			
	b. Are bartenders hired by you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Or establishment where event is held?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. If hired by you, have the bartenders been trained in TIPS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. What procedures are in place to limit drinking?			
	– Tickets provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	– Cash bar?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	– Open bar?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. Is a Liquor Liability policy in place covering this event?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f. Liquor License required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART VII: AUTOMOBILE N/A

1.	Are all vehicles insured on the schedule titled to the Named Insured? If no, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are keys locked and secured away from clients when not in use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are vehicles with 8 or more seating capacity equipped with an audible backup warning device?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	If you operate 15 passenger vans, do you routinely check for proper tire inflation? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Are vehicles checked after passengers disembark to make sure no one is left behind?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you require seat belts to be worn by all occupants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Explain your vehicle maintenance program:	
9.	Do you accept donated vehicles? If yes, when and how does title transfer to you? Explain: Do you repair any vehicles? If Yes, describe the types of repairs: If you sell the donated vehicles yourself, do you sell them "as is" with no guarantees? If no, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

PART VIII: HIRED AND NONOWNED EXPOSURE N/A

1.	Do you hire vehicles? If Yes, what types of vehicles do you hire?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you obtain certificates of insurance? What minimum limits do you require?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you hire from a transportation company? If Yes, with drivers?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Total number of hired vehicles annually: _____ Annual cost of hire: _____	
4.	Do employees/volunteers transport children in their own vehicles? If Yes, how often?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	How many drive personal vehicles for business use regularly? F/T: _____ P/T: _____ Vol: _____ How many drive personal vehicles for business use occasionally? F/T: _____ P/T: _____ Vol: _____	
	Do you obtain proof of insurance for employees/volunteers who use their own autos with minimum limits of \$100,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you update your records at least annually?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IX: DRIVER INFORMATION N/A

1.	Do you obtain a written authorization to release driver information from all of your staff upon hiring? Do you obtain MVRs on all drivers? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how often?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Explain procedures for dealing with driver accidents or violations:	
3.	Are all drivers at least 21 years of age? How many drivers are over age 70?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have drivers attended a class in defensive driving? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Is training provided for new employees/volunteers prior to their transporting clients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Does anyone besides employees or volunteers drive your vehicles? If Yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Is personal use of Insured's vehicles permitted? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART X: RESIDENTIAL N/A

RESIDENTS	# BEDS	RESIDENTS	# BEDS
Group Home		Shelter – Homeless	
Intermediate Care		Shelter – Other	
Independent Living		Transitional Housing	
Low Income Housing		Hospice	
Shelter – Abuse Victims		Other (specify)	

1.	Annual number of clients by age group: Less than 18: _____ 18-34: _____ 35-65: _____ Over 65: _____	
2.	Annual number of clients by category: Emotional/Behavioral: _____ Drug/Alcohol: _____ Physical/Intellectual Disabilities: _____	
3.	Specify number of Male: _____ Female: _____	
4.	Are residents separated? How are they separated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Average length of stay:	
6.	Number of non-ambulatory patients: _____ What floor are they located on? _____	
7.	Total number of rooms: _____ Number of bedrooms: _____	
8.	What was the date of the last inspection by a licensing agency? Were there any violations or deficiencies noted? If Yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Does a physician screen clients prior to admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART X: RESIDENTIAL N/A (continued)

10.	Do you require signed release forms for the release of records to other individuals or institutions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Are residents primarily responsible for their own basic personal care including bathing, dressing, eating, and restroom aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Is the staff trained in non-violent crisis intervention? If Yes, which protocol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	What is the ratio of residents to staff: Day: _____ Night: _____	
14.	What procedures are in place for clients who are permitted to leave the premises without supervision?	
15.	How many visits per month are made by a caseworker to a resident?	
16.	How often are rooms inspected? _____ Who inspects the rooms? Do you have written procedures? Do you keep a checklist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
17.	How often are bed checks done? _____ <input type="checkbox"/> Random <input type="checkbox"/> Scheduled	
18.	Are there security cameras monitoring operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Are residents' doors ever locked from the outside?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Are residents allowed to cook their own meals? If Yes, in <input type="checkbox"/> Private or <input type="checkbox"/> Common cooking areas?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART XI: OUTPATIENT FACILITIES N/A

TYPE OF SERVICE	# VISITS	TYPE OF SERVICE	# VISITS

1.	Annual number of clients by age group:	Less than 18:	18-34:	35-65:	Over 65:
2.	Annual number of clients by category:	Emotional/Behavioral: Physical/Intellectual Disabilities:		Drug/Alcohol: Mental Health:	
3.	Explain screening procedures for clients:				
4.	Do you operate a clinic? If Yes, is it open to the public?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			
5.	Do you operate a crisis hotline? If Yes, annual number of calls received: What types of calls? <input type="checkbox"/> Drug/Alcohol <input type="checkbox"/> Child/Spousal Abuse <input type="checkbox"/> Other: What are the hours of operation for the hotline? Is training provided? Do volunteers answer calls?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			
6.	Do you provide adult day care? If yes, complete Adult Day Care Center section within this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
7.	Do you provide any programs for sexual offenders? If yes, number of visits and describe typical offenses:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
8.	Do you provide any programs for juvenile delinquents? If yes, number of clients and describe typical offenses:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
9.	Do you provide any services for ex-offenders or incarcerated individuals? If yes, number of clients and describe typical offenses:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
10.	Do you provide respite care programs? If Yes, maximum amount of consecutive days: Do you <input type="checkbox"/> take all ages or <input type="checkbox"/> do you specialize? Explain: Can parents/caretakers meet and interview the people who will be providing the care? How far ahead of time do parents/caretakers need to call to arrange for services? Do you maintain records of services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			
11.	Do you operate a meal delivery service? If Yes, number of meals annually: Do you charge a fee? If Yes, total revenue: \$	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			

PART XII: SUBSTANCE ABUSE PROGRAMS N/A

1.	Is treatment <input type="checkbox"/> individual or <input type="checkbox"/> group? Number of group sessions annually: _____ Number of individual sessions annually: _____	
2.	Do you provide a methadone maintenance program? If yes, where is the methadone stored? Number of methadone-only clients annually: Number of clients with take home privileges: Describe measures to guard against the diversion of methadone by employees and/or clients:	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you operate a detoxification unit? If Yes, <input type="checkbox"/> Medical <input type="checkbox"/> Other If Medical, do you accept clients with a history of delirium tremens (DTs) or seizures? If clients are experiencing DTs or seizures, do you <input type="checkbox"/> treat them or <input type="checkbox"/> refer them to a hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you operate drug/alcohol rehabilitation? If Yes, are these for adults only? Are facilities single sex? <input type="checkbox"/> Yes <input type="checkbox"/> No Co-ed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

PART XIII: THERAPEUTIC HORSEBACK RIDING N/A *Attach a copy of medical, rider's registration, and liability release forms.*

1.	Are liability waivers signed by all parents/guardians?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you follow North American Riding for the Handicapped Association standards?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you or your instructors have regional or national riding certificates?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you fasten a child to any part of the saddle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Are safety helmets mandatory?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you provide transportation to and from the facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Total annual lessons: _____ Average size of group: _____	
8.	What is the experience of the staff?	
9.	What is ratio of riders to counselors? _____ Minimum age of riders: _____	

PART XIV: FOOD BANK N/A **THRIFT STORE** N/A

1.	Are goods properly stored and stacked? Are any goods kept outdoors? If Yes, explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are forklift operators properly trained and supervised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you provide pick up services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	How many drop-off containers and/or pick up containers do you have?	
5.	Do you pick up from homes or businesses? What radius do you drive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you have a loading dock or appropriate place to unload goods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	How often are incoming goods sorted to identify spoiled and/or hazardous goods?	
8.	Are unwanted goods disposed of promptly and properly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are product expiration dates monitored?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART XV: POOL N/A

1.	Is there a trained lifeguard on duty? If Yes, how many? _____ During what hours? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	The pool area includes: <input type="checkbox"/> Jacuzzi <input type="checkbox"/> Whirlpool <input type="checkbox"/> Hot tub <input type="checkbox"/> Spa <input type="checkbox"/> Kiddie pool <input type="checkbox"/> Water slide <input type="checkbox"/> Trampoline	
3.	Is the pool completely fenced with a self-locking gate? If Yes, what is the height?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Pool location: <input type="checkbox"/> Indoors <input type="checkbox"/> Outdoors	
5.	Is there a diving board? If Yes, what is the height?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Are depths clearly marked? Is walking surface around the pool non-skid and in good condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

PART XV: POOL N/A (continued)

7.	Is life saving equipment readily accessible?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Is the staff trained in water safety?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are all areas of the pool, including the bottom, visible at all times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Are "swim at your own risk" signs posted with pool rules?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do the posted rules meet state and local regulations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Do you have specific guidelines regarding closing the pool due to water contamination?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART XVI: PLAYGROUND N/A

1.	Is the playground area supervised during all open hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Is the play area fenced?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, describe fencing:	
3.	Describe surface under playground equipment:	
	Depth of surface:	
4.	Is the playground equipment properly checked?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART XVII: RECREATION / COMMUNITY CENTER N/A

1.	Is there an admission charge or membership fee to use the center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you require hold harmless/waivers to be signed by all users?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you have swimming facilities? If yes, complete Pool section within this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have the following (select all that apply)? <input type="checkbox"/> Gym <input type="checkbox"/> Basketball <input type="checkbox"/> Boxing <input type="checkbox"/> Weightlifting	
5.	Do you have a playground? If yes, complete Playground section within this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Is there an emergency evacuation plan in place in event of fire, storms, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you have an accident investigation plan in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Do you have an accident policy in place? If yes, what are the limits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Average Daily Attendance of all activities:	
10.	Average Daily Attendance of children in designated day care center (not including temporary child watch), if applicable:	
11.	Describe any activities not listed above:	

PART XVIII: CAMPS N/A

1.	Is written permission/waiver of liability obtained from every child's parent or guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Does the camp provide overnight services? If Yes, what is the average length of stay?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Total number of days in operation annually: _____ Number of children at each camp: _____	
4.	Number of staff members at each camp:	
5.	What are the qualifications of staff working with children?	
6.	Are sleeping quarters co-ed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are restrooms/showers co-ed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	If well water, how often is it tested?	
8.	Indicate and describe if any of the following exposures exist in the camp operations:	
	<input type="checkbox"/> Obstacle course <input type="checkbox"/> Motor boats <input type="checkbox"/> Archery <input type="checkbox"/> Jet skis <input type="checkbox"/> Water skiing <input type="checkbox"/> Pools <input type="checkbox"/> Guns <input type="checkbox"/> Rock climbing <input type="checkbox"/> Diving boards <input type="checkbox"/> Horses <input type="checkbox"/> Lakes <input type="checkbox"/> Other: _____	

PART XIX: ADULT DAY CARE CENTER N/A

1.	Staff to client ratio?	
2.	What percentage of clients have dementia or Alzheimer's? %	
3.	Is there a policy in place on how to deal with a client who may wander off? If yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Are any clients non-ambulatory? If yes, Is there an emergency evacuation plan in place? Is facility fully wheelchair accessible?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Are physical exams required prior to enrolling in center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do staff members administer medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Are medicines kept locked when not in use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are written records kept on all clients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Do you transport clients to and from the center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Describe activities that occur on premises:	
11.	Are there any off premises activities/field trips? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART XX: SHELTERED WORKSHOP N/A

1.	Do the jobs involve: Power tool/Power equipment Plastic molding? Woodworking/Pallet manufacturing? Spray painting? Electrical wiring? Welding? Heat sealing? Chemicals? Janitorial Services? If yes, provide annual payroll \$ Landscaping/Lawn care? If yes, provide annual payroll \$ Other types of jobs provided (be specific):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you contract with manufacturers for particular projects? If yes, do your contracts include a hold-harmless clause favoring the workshop? Do any of your contracts require you to indemnify the manufacturers? If yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are you named as an Additional Insured on the manufacturer's policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Are clients covered by worker's compensation insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Average number of clients daily:	
6.	Staff to client ratio:	
7.	Do staff make follow up visits to clients placed in outside employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART XXI: WEATHERIZATION N/A

Please mark with an "X" what services are provided and indicate if work is done by volunteers (V), employees (E) and/or sub-contractors (S):

	Services	Payroll	Employees, Volunteers or Sub-Contractors
<input type="checkbox"/>	Air Conditioning and Heating		
<input type="checkbox"/>	Plumbing		
<input type="checkbox"/>	Insulation		
<input type="checkbox"/>	Carpentry		
<input type="checkbox"/>	Electrical Wiring		
<input type="checkbox"/>	Roofing		
<input type="checkbox"/>	Exterior Painting and/or Siding		
<input type="checkbox"/>	Framing		
<input type="checkbox"/>	Foundation		
<input type="checkbox"/>	Pressure Cleaning		
<input type="checkbox"/>	Patio, Deck or Ramp Installation		
<input type="checkbox"/>	Window Installation		

Other – Describe:

1. Sub-Contractor Information:	<p>Do you obtain certificates of insurance for all sub-contractors with minimum limits of \$1,000,0000 and are the limits equal to or greater than your current limit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you require all sub-contractors to name you as an additional insured on their general liability policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you require sub-contractors to sign written construction contracts containing indemnity/hold harmless clauses in your favor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you obtain criminal background checks on all sub-contractors (mandatory requirement)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
2. Employees and Volunteers:	<p>Are the employees and or volunteers skilled and experienced on the type of worked performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:</p> <p>Are volunteers appropriately licensed in their respective trades? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there a written safety and security procedures in place? (OSHA) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is workers compensation carried for all employees and volunteers? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you handle any hazardous materials? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, are they properly stored? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you own or rent scaffolding? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Own <input type="checkbox"/> Rent Who erects the scaffolding?</p> <p>Any Exterior Insulation Finishing System (EIFS)? <input type="checkbox"/> Yes <input type="checkbox"/> No a. What kind? <input type="checkbox"/> Traditional <input type="checkbox"/> Drainable? b. Are they certified installers? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Additional Comments on the program underwriting may need to know:

Please attach the following:

- | | |
|---|---|
| <input type="checkbox"/> ACORD applications, including Crime and Umbrella | <input type="checkbox"/> Loss runs for current year and 3 prior years |
| <input type="checkbox"/> Statement of values, if applicable | <input type="checkbox"/> Brochure and/or newsletter |
| <input type="checkbox"/> Schedule of vehicles | <input type="checkbox"/> Financial statement if for-profit |
| <input type="checkbox"/> Drivers list with license numbers and dates of birth | <input type="checkbox"/> Photographs – residential locations |

NOTICE TO APPLICANT – PLEASE READ CAREFULLY

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED WARRANTS THAT TO THE BEST OF HIS/HER KNOWLEDGE THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO ISSUE, OR THE APPLICANT TO PURCHASE, ANY INSURANCE POLICY.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER. THIS APPLICATION WILL BECOME A PART OF SUCH POLICY, IF ISSUED. THE INSURER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING THIS POLICY. IN THE EVENT THAT THE APPLICATION CONTAINS ANY MISREPRESENTATION OR MISSTATEMENT OF A MATERIAL FACT, THIS POLICY SHALL NOT AFFORD COVERAGE TO ANY INSURED WHO KNEW OF SUCH MISREPRESENTATION OR MISSTATEMENT.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT MUST PROVIDE WRITTEN NOTIFICATION TO THE INSURER, WHO MAY MODIFY OR WITHDRAW THE QUOTATION.

THE UNDERSIGNED FURTHER AGREES TO AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION IN THIS APPLICATION TO A LOSS CONTROL PROVIDER THAT PROVIDES LOSS CONTROL SERVICES TO THE INSURER AND TO COMPLY WITH THE TERMS AND CONDITIONS OF THOSE LOSS CONTROL SERVICES.

THE UNDERSIGNED DECLARES THAT THE INDIVIDUALS AND ORGANIZATIONS PROPOSED FOR THIS INSURANCE HAVE BEEN NOTIFIED THAT:

- A.** THIS POLICY APPLIES ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE; AND
- B.** THE LIMIT OF LIABILITY IS REDUCED BY AMOUNTS INCURRED AS DAMAGES AND SUCH EXPENSES WILL BE SUBJECT TO THE DEDUCTIBLE AND/OR CO-PAYMENT AMOUNT.

FRAUD STATEMENT

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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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 for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FRAUD STATEMENT TO DISTRICT OF COLUMBIA APPLICANTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT 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 of the third degree.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT TO NEW YORK APPLICANTS

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

FRAUD STATEMENT TO OHIO APPLICANTS

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FRAUD STATEMENT TO OKLAHOMA APPLICANTS

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FRAUD STATEMENT TO PENNSYLVANIA APPLICANTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD STATEMENT TO TENNESSEE 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.

FRAUD STATEMENT TO VIRGINIA 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.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, or VT; in DC, LA, ME, TN, and VA, insurance benefits may also be denied.)

I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE INFORMATION PROVIDED IS TRUE AND CORRECT AND THAT NO INFORMATION WHICH MATERIALLY AFFECTS THIS INSURANCE HAS BEEN WITHHELD. THE INSURER IS AUTHORIZED (BUT NOT OBLIGATED) TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. ACCEPTING THIS APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE INSURANCE.

APPLICANT'S SIGNATURE: _____ DATE: _____

AGENT'S SIGNATURE: _____ DATE: _____