Send submissions to nonprofit@minico.com
800-528-1056 • www.minico.com

MINICO
A JENCAP® COMPANY

HEALTH, HUMAN AND SOCIAL SERVICES APPLICATION

GENERAL INFORMATION

Insured Name ____

Address ____

Telephone ___________________

Agency ___________________________________

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. Describe the operations ____
   ____
4. Insured Website ________________________________
5. Name of Director _______________________________
6. Annual budget _________________________
7. Describe the insured's funding ____
8. Is the insured's facility licensed? ☐ Yes ☐ No   If so, submit copies of all licenses.
9. Has any license ever been suspended or revoked? ☐ Yes ☐ No
   If Yes, explain: ____
10. Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines?
    ☐ Yes ☐ No If Yes, explain: ____
11. Has any insurer cancelled, declined, or refused renewal? ☐ Yes ☐ No
    If Yes, why? ____

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 the tenants required to carry liability 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

B) Protective Devices/Safety Information

Automatic Sprinklers ☐ Yes ☐ No

Carbon Monoxide Detectors ☐ 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? _______________

 Copyright © MiniCo Insurance Agency CA License 0H04984

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 preventative 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

Residential Housing ☐ *Does not apply*

1. Is the property subject to HUD inspections? ☐ Yes ☐ No If Yes, attach a copy of the REAC report.
2. Is smoking permitted inside any location? ☐ Yes ☐ No
3. Are all units equipped with smoke detectors? ☐ Yes ☐ No
   If Yes, ☐ hardwired ☐ battery operated ☐ hardwired with battery backup
4. Are all units equipped with carbon monoxide detectors? ☐ Yes ☐ No
5. Do you allow grills or fire-pits on patios or balconies? ☐ Yes ☐ No
6. Are all buildings over three stories sprinklered in all living areas? ☐ Yes ☐ No
7. Are there any non-ambulatory tenants? ☐ Yes ☐ No
   If Yes, how many by location? ____
8. Do any tenants have the following disabilities: sex offenders, schizophrenia, violent, suicidal, Alzheimer's, dementia or severely mentally ill? ☐ Yes ☐ No
   If Yes, please provide details on tenant disabilities: ____
   ____
9. Does your organization provide any social services? ☐ Yes ☐ No
   If Yes, please explain: ____
10. Do you provide security? ☐ Yes ☐ No If Yes, are they armed? ☐ Yes ☐ No
11. Are any buildings vacant? ☐ Yes ☐ No
12. Do you have any plans for renovations or new construction? ☐ Yes ☐ No
    If Yes, please describe: ____
    ____

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: ____

____

Section 2) **Special Fund Raising / Sports Events** ☐ Yes ☐ No

If yes, complete Special Events supplemental application

Section 3) **<u>Sexual Misconduct</u>** ☐ *Does not apply*

Current Limits: ________ Occurrence / Aggregate

1. Are all current and prospective employees and volunteers (that interact with clients) checked with the Child Abuse Register and with law enforcement agencies for Criminal records, including fingerprinting? ☐ Yes ☐ No
2. What is the age group of clients? ____________________
3. What is the ratio of staff to clients? ____________________
4. Is there more than one person responsible for the welfare of any single client? ☐ Yes ☐ No
   If No, describe why unnecessary:____
5. Are there rules or guidelines prohibiting closed door one-on-one meetings? ☐ Yes ☐ No
   If No, describe why unnecessary: ____
6. Are there written complaint procedures and are they displayed prominently? ☐ Yes ☐ No
   If No, describe why unnecessary: ____
7. 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, including fingerprinting? ☐ 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
8. Do volunteers work directly with clients? ☐ Yes ☐ No
9. Have any employees been the subject of 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 the 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 written documentation procedure on how allegations of abuse are handled? ______________________________
    ____
19. Are accused employees removed from client care responsibilities pending outcome of investigation? ☐ Yes ☐ No
    If No, please describe: ____
20. What procedures have been instituted to prevent reoccurrences of previous events? ________________________________
    ____

Section 4) **Foster Care / Adoption** ☐ Yes ☐ No

NOTE: This class is not eligible for the Liberty Mutual program. Please inquire about other available options.

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

Location Number(s): ____________________

1. Description of premises: ____________________
   Private Home ☐ Commercial Building ☐ School ☐
2. Interest: Owner ☐ Tenant ☐
3. Describe affiliation (church, school, other): ____________________
4. Part occupied by applicant (i.e., basement, 1st floor, 2nd floor): ____________________
5. Area occupied (sq. ft. dimensions): ____________________
6. Does Applicant have a playground? ☐ Yes ☐ No
   If Yes, describe equipment and list security measures (e.g. locked gates, etc.)
   ____
7. Was playground equipment professionally installed? ☐ Yes ☐ No
8. Is the playground equipment inspected and maintained at least annually? ☐ Yes ☐ No
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)			Animals, pets		
Physical/Mentally handicapped or developmentally disabled children			Gymnastic equipment		
Nurses, Therapists, Counselors			Unique/unusual teaching techniques		
Field trips					

Remarks: ____________________

____

10. 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.
11. Does Applicant require parental release of liability for all children? ☐ Yes ☐ No
    If No, will you institute such a program? ☐ Yes ☐ No
12. 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: _____
13. Applicant's ratio of supervisors to children is _____ to _____
14. 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. Is the applicant engaged in, owned by, associated with or involved in any other enterprises? ☐ Yes ☐ No
   If Yes, describe: ____________________

Section 7) **Type of facility**

	Total # of beds	Age of residents	M – Male F – Female or both	Average Length of stay	Client-staff ratio	Percentage of Non-Ambulatory Clients
Alcohol or Drug – Rehab						
Alcohol or Drug – Treatment						
Alcohol or Drug – Detoxification						
Psychiatric Care						
Shelter for runaways, abused spouses, foster children						
Homeless Shelter Facility						
School: (state type of school): __________						
Group home – Mental/Physical Rehab						
Group home – Developmentally Disabled						
Group home – Troubled Youth						
Transitional Housing – Low-income						
Aged - Independent living						
Aged - including intermediate care						
Aged - including skilled care						
Hospice						
Nursing home for senile or aged						
Other (specify):						

How many total beds are you licensed for?_______________ How many beds are currently occupied? ___________

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

Number of bedridden clients: _________

Section 8) **Type of Client at all facilities above**

	Percentage of Clients
Somewhat mentally impaired (i.e. Senile)	
Seriously mentally impaired (i.e. Alzheimer's)	
Aged but mentally and physically fully functional	
Mentally/Physically disabled requiring **intermediate care**	
Mentally/Physically disabled requiring **skilled care**	
Other (Specify):	

1. What floors are the non-ambulatory patients on? ___________ How many patients are on each floor? ___________
2. Are restraints used? ☐ Yes ☐ No If Yes, attach copies of restraining procedures that are in force.
3. Other operations:

   ☐ Counseling # of visits: ______

   ☐ Home care # of visits: ______

   ☐ Daytime care # of clients: ______

   ☐ Other (specify): ________________________
4. If counseling is provided, describe (e.g., group therapy, individual counseling): ____

   ____
5. List other types of services provided (e.g., beautician services, podiatry, dentistry): ____________________________________

   ____

   Provided for: ______________________ By staff: ______________________ By Contractors: ______________________
6. Ages of patients:

   ☐ Under 18 ☐ 18-35 yrs old ☐ 36-50 yrs old ☐ 51-65 yrs old ☐ Over 65

   Client to Staff Ratio: _________
7. 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

8. Do any patients work full or part time jobs? ☐ Yes ☐ No

   If Yes, what percentage of patients work? _____% What type of work: ____________________

9. Are any medications administered? ☐ Yes ☐ No

   If Yes, list any medication administered and in what form given (e.g., Methadone, given in pill form):

   ____

10. Is a Registered Nurse or M.D. on duty at all times? ☐ Yes ☐ No If No, explain availability: __________________________

    ____

11. Is any facility used for detoxification (withdrawal) of drug addicts and/or alcoholics? ☐ Yes ☐ No

    If Yes, Explain: ____

Section 9) **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

   **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
2. Does insured operate a clinic? ☐ Yes ☐ No If Yes, annual number of visits: _____
3. Does insured operate a suicide crisis hotline? ☐ Yes ☐ No If Yes, annual # of calls received: _____
4. Do you provide any services/programs for violent ex-offenders, including sexual predators? ☐ Yes ☐ No
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: ____

Section 10) **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.

Section 11) **Any of the following performed:**

Spray painting:	Yes	No
Discharge of fumes:	Yes	No
Discharge of acids or wastes:	Yes	No
Use of radioactive materials:	Yes	No

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

Section 12) **Recreational Camps** ☐ Yes ☐ No
If yes, complete Camps supplemental application

Section 13) **Residential Housing** ☐ *Does not apply*
1. Is the property subject to HUD inspections? ☐ Yes ☐ No If Yes, attach a copy of the REAC report.
2. Is smoking permitted inside any location? ☐ Yes ☐ No
3. Are all units equipped with smoke detectors? ☐ Yes ☐ No
   If Yes, ☐ hardwired ☐ battery operated ☐ hardwired with battery backup
4. Are there any commercial cooking facilities? ☐ Yes ☐ No
5. If yes, is there a UL300 / NFPA 96 fire suppression system in place? ☐ Yes ☐ No
6. Are all units equipped with carbon monoxide detectors? ☐ Yes ☐ No
7. Do you allow grills or fire-pits on patios or balconies? ☐ Yes ☐ No
8. Are all buildings over three stories sprinklered in all living areas? ☐ Yes ☐ No
9. Are there any non-ambulatory tenants? ☐ Yes ☐ No
   If Yes, how many by location? ______________________________________
10. Do any tenants have the following disabilities: sex offenders, schizophrenia, violent, suicidal, Alzheimer's, dementia or severely mentally ill? ☐ Yes ☐ No
    If Yes, please provide details on tenant disabilities: ____
    ____
11. Does your organization provide any social services? ☐ Yes ☐ No
    If Yes, please explain: ____
12. Do you provide security? ☐ Yes ☐ No If Yes, are they armed? ☐ Yes ☐ No
13. Are any buildings vacant? ☐ Yes ☐ No
14. Do you have any plans for renovations or new construction? ☐ Yes ☐ No
    If Yes, please describe: ____
    ____

Section 14) **In-Home Support Services** ☐ *Does not apply*

1. **Services Provided:**

Nursing care	Speech therapy	Bathing
Changing catheters	Social work	Laundry
Infusion therapy	Nutrition counseling	Meal preparation
Medical management	Repositioning	Housework
Blood testing	Restroom aid	Dressing
Feeding tube	Other: ________________________	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 15) **Employee Dishonesty Supplement** ☐ *Does not apply*

GENERAL

1. Total number of employees: _____ Total number of volunteers: _____
2. Number of employees and/or volunteers who handle money, securities or other property: _____
3. Do you expect the number of employees/volunteers to grow substantially this year? ☐ Yes ☐ No
4. Name of current insurance carrier and employee dishonesty limits: ____
5. Why are you requesting this limit? ____

LOSSES

1. List any crime losses during the past 5 years: (including 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 circumstances: ____

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
   If Yes, 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?
   ☐ All Levels ☐ $1,000 or less ☐ $1,001 - $2,500 ☐ $2,501 - $5,000 ☐ Over $5,000
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
   If Yes, 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 and deposit slips sent direct to the main office by the bank? ☐ Yes ☐ No

 Copyright © MiniCo Insurance Agency CA License 0H04984

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 and 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: ______________________________
   Handle Bank Deposits: ______________________________
   Approve Payroll: ______________________________

Section 16) **Auto Supplement** ☐ *Does not apply*

1. Are patients/clients transported in company owned vehicles? ☐ Yes ☐ No
2. Describe the type of occupants:
   ☐ Physically Handicapped ☐ Elderly
   ☐ Mentally Handicapped ☐ Non-Ambulatory
   ☐ Children ☐ Other (describe): ______________________
3. List Safety Measures on board vehicles:

• Is seat belt use mandatory?	Yes	No
• Is there a matron on board?	Yes	No
• Are there wheelchair lifts?	Yes	No
• Any medical support equipment on board?	Yes	No
• Are there wheelchair mounts within vehicle?	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 travel between states? ☐ Yes ☐ No If Yes, how often and for what purposes?:
   ____
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 21 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. Does the insured obtain copies of auto policies from volunteers or employees? ☐ Yes ☐ No
21. 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 17) **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 and/or transport clients using their own vehicles for company business? _____
5. Do you obtain copies of insurance policies for volunteers and employees who use their own vehicles? ☐ Yes ☐ No
6. Are these records updated at least yearly? ☐ Yes ☐ No
7. Do you require insurance limits of at least 100/300/100? ☐ Yes ☐ No
   If No, what limits do you require? __________
8. Are MVRs checked on volunteers/employees? ☐ Yes ☐ No
9. Do you have a driver safety program? ☐ Yes ☐ No
10. Are seat belts required to be worn by all occupants? ☐ Yes ☐ No
11. 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: ___________

Current Limits: ________________________ Occurrence/Aggregate

1. Describe professional services provided: ____
2. HAS APPLICANT HAD ANY INCIDENTS IN THE LAST FIVE YEARS THAT MAY GIVE RISE TO A CLAIM? Yes No
3. Total client contacts per year: _________________

   **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

4. Please provide the number of each type of **caregiver** below (excluding clerical or administrative staff):

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

Please include a <u>STAFF PROFILE</u> with your submission.

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

5. Do you have any contractual agreements to provide services? ☐ Yes ☐ No

   If Yes, please describe: ____

ATTACHMENT A

PHYSICIAN APPLICATION
(To be completed entirely for each Physician, Psychiatrist, Dentist, etc.)

Social Service Organization Name:

1. Name of Individual Practitioner: | Degree: ☐ MD ☐ D.O. ☐ Other: | Board Certified? ☐ Yes ☐ No

2. What is your relationship to the Social Service Organization: ☐ Owner ☐ Volunteer ☐ Employee ☐ Independent Contractor ☐ Other:

3. List below all professional schools attended:

NAME	CITY	STATE	YRS. ATTENDED	DATE GRADUATED	DEGREE

STATE OF LICENSE	LICENSE NUMBER

4. List your Medical/Surgical Specialty:

5. Responsibilities for the Social Service Organization, including any administration or prescription of medication:

6. How many hours per week do you work on behalf of the Organization

7. – 10. If Yes, please give details on reverse side of page.

7. Do you perform surgery on behalf of the Organization?	☐ Yes ☐ No
8. Have you ever had a malpractice claim or suit filed against you?	☐ Yes ☐ No
9. Have you ever had your license revoked, suspended, or restricted?	☐ Yes ☐ No
10. 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

11. Note: The policy provides coverage for *Insured Organization* for acts or omissions of physicians performing services on behalf on the insured organization. However, unless the policy is specifically endorsed, no coverage is provided for any employed, volunteer or contracted physician.

12. Do you currently carry your own malpractice insurance? ☐ Yes ☐ No

13. If Yes, does your insurance cover you for services you perform on behalf of the Organization? ☐ Yes ☐ No

Please provide the following information regarding your professional liability coverage:

Insurance Company	Coverage Date	Retroactive Date	Policy Limits	Premium	Claims Made Form?
					☐ Yes

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and (NY: substantial) civil penalties. In Maine and Virginia, insurance benefits may also be denied.

Applicant's Signature: ______________________ Date: ____________

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

Fraud Warning

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.

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 __________________