***CLAIMS MADE/OCCURRENCE DISCLOSURE NOTICE***

***THE POLICY YOU ARE APPLYING FOR MAY CONTAIN BOTH CLAIMS MADE AND OCCURRENCE COVERAGES. PLEASE READ THE POLICY IN ITS ENTIRETY. SOME OF THE PROVISIONS CONTAINED IN THE POLICY RESTRICT COVERAGE, SPECIFY WHAT IS AND IS NOT COVERED AND DESIGNATE RIGHTS AND DUTIES.***

The requested information is necessary before a quotation can be obtained. Type or print clearly. Use 🗷 for Yes or No answers and other selections.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply. Provide any supporting information on a separate sheet and reference the applicable question number.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application. The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

**Supporting information:**

Along with this completed and signed application, the applicant must also submit the following information:

* Five (5) years of currently valued loss runs
* For losses exceeding $50,000 and/or loss of life, physical or sexual abuse, please attach a detailed description of said loss/incident. Advise what measures have been taken to prevent similar losses from occurring in the future.
* Agency descriptive and/or brochures
* Audited financial Statements
* Human Services Supplement – Abuse Exposure Evaluation
* Human Services Addiction Treatment and/or Behavioral Healthcare Supplement.

|  |
| --- |
| **SECTION I – GENERAL INFORMATION** |

1. Applicant/Agency Name (Named Insured as it reads on policy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Federal ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

4. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Operating as: ☐Individual ☐Partnership ☐Corporation ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Applicant is: ☐For Profit ☐Non-Profit ☐Government Facility ☐Other: \_\_\_\_\_\_\_\_\_\_

8. Executive Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Contact Person for:

Human Resource: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Current Operating Budget: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of Operation:\_\_\_\_\_\_\_\_\_

11. Annual Revenues for each of the past 2 (two) years: 20\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_\_\_

12. Primary Funding Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Has Applicant ever filed for protection under Chapter 11 or Chapter 7 of Bankruptcy code ☐Yes ☐ No(title 11 US Code)?

14. State Agency(s) in which license(s) are held: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Expiration dates of current State Licenses: Residential: \_\_\_\_\_\_\_ Day Programs: \_\_\_\_\_ Others: \_\_\_\_\_

16. Are there any Serious Deficiencies noted in most recent Re-Certifications/Compliance Audits? ☐Yes ☐No

If Yes, please attach list and describe:*.*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. What state and national Organization(s) or Association(s) is Applicant a member of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Is Applicant accredited (e.g. CARF, ACO, JCAHO, etc.) ☐Yes ☐ No

If Yes, what agency/program, level and expiration dates? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. Does Applicant have any Subsidiaries/Holding Corps/Related Organizations with your equity ☐Yes ☐ Nointerest? If Yes, please list & describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Does Applicant have a Pension/Welfare plan? ☐ Yes ☐ No

If Yes, please name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. Does Applicant act as a Managed Care Organization or Gatekeeper? ☐Yes ☐ No

22. List Special Events (i.e. - Special Olympics, Fund Raising, Annual Banquet, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
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| **SECTION II – RISK MANAGEMENT** |

1. Does Applicant have procedures for Incident Reporting? ☐ Yes ☐ No

a) Is staff made aware of Incident Reporting Procedures? ☐ Yes ☐ No

b) Are program participants instructed on how to report incidents? ☐ Yes ☐ No

c) Does Applicant have an active committee that reviews incidents? ☐ Yes ☐ No

2. Does Applicant have policies & procedures in place for Prescribing/Administering Medication?

1. Who prescribes/administers medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are Non-FDA drugs prescribed or administered? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Where and how are drugs stored? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does the Applicant have an active Safety Committee? ☐ Yes ☐ No

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| **SECTION III – TRANSPORTATION** |

If you do not have any owned/leased autos please skip this Section and complete the Non-Owned & Hired Auto Supplement

1. Does the Applicant order Motor Vehicle Records on all drivers? ☐ Yes ☐ No

If Yes, are they ordered at least Annually? ☐ Yes ☐ No

2. Does Applicant order Motor Vehicle Records on new hires, including prospective employees?☐ Yes ☐ No

3. If the Applicant utilizes volunteer or contracted drivers, are they subject to all of the same qualifications as full-time and part-time drivers?  Yes  No

4. What are the Applicant’s standards for acceptable MVR’s?

5. Is there an experience requirement for newly hired drivers?  Yes  No

If Yes, what is the experience requirement?

6. Are you enrolled in a state notification system for drivers? ☐ Yes ☐ No

7. Are all vehicles registered in the insured’s name? ☐ Yes ☐ No

8. Is there a vehicle maintenance program in place? ☐ Yes ☐ No

9. Does Applicant lend/lease its vehicles to other agencies? ☐ Yes ☐ No

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. .Does Does the Applicant transport anyone other than agency clients? (i.e., Public/School/Seniors) ☐ Yes ☐ No

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Do any staff members use their own personal vehicles on a regular basis for agency business?☐ Yes ☐ No

If Yes, please indicate how many: \_\_\_\_\_\_\_\_\_\_

If No, please skip to question #15.

12. Do any staffmembers use their own personal vehicles to transport clients? ☐ Yes ☐ No

If Yes, please indicate how many: \_\_\_\_\_\_\_\_\_\_

If No, please skip to question #15.

13. Does Applicant require employees to provide certificates of insurance verifying personal ☐ Yes ☐ No

automobile coverage?

14. Does Applicant require employees to carry liability insurance at the state required ☐ Yes ☐ No

minimum amount?

15. Total # of Agency owned vehicles: \_\_\_\_\_\_\_\_\_\_ Total # of drivers: \_\_\_\_\_\_\_\_\_\_

a) Does Applicant allow clients under the age of 21 to drive agency vehicles? ☐ Yes ☐ No

b) Does Applicant allow employees under the age of 21 to drive agency vehicles? ☐ Yes ☐ No

If Yes to either question, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c) Does Applicant have drivers over the age of 65? ☐ Yes ☐ No

If Yes, are physical abilities tests performed? ☐ Yes ☐ No

14. In the past twelve months, how many drivers were Added:       Replaced:

16.How many 12/15 Passenger Vans does the Applicant utilize? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

17.

For what purpose are the 12/15 Passenger Vans utilized? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. If Applicant operates buses, is there a bus maintenance program? ☐ Yes ☐ No

If No, Please skip to Section IV. Staffing.

If Yes, please explain and complete questions a, b, and c below.

a) Do drivers hold the appropriate type of licenses? ☐ Yes ☐ No

b) Does Applicant have back up drivers that hold the appropriate licenses? ☐ Yes ☐ No

c) What type of training is provided to drivers of the buses? Please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION IV – STAFFING** |

1. Please indicate total:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **# of Full Time:** | **# of Part Time:** | **Turnover Ratio %:** | **# of Board Members:** | **# of Volunteers:** |
|  |  |  |  |  |

2. Annual Payroll: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Exposure count by Classification:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Classification** | **Employed** | | **Contracted** | |
| Homemakers, Sitters, Companions, Home Health Aides, Clerical, Administrative | **Full – Time** | **Part-Time** | **Full – Time** | **Part-Time** |
| Medical Office Assistants, Patient Intake Technicians, Interventionists/Certified Addiction Recovery Coach, Volunteers providing healthcare professional services (excluding psychiatric of physician services) |  |  |  |  |
| Dieticians / Nutritionists |  |  |  |  |
| Recreation, Art, Dance, or Music Therapists |  |  |  |  |
| Licensed Practical Nurse (LPN) |  |  |  |  |
| Pharmacy Assistants |  |  |  |  |
| Registered Nurses (RN’s), Social Workers, Addiction Counselors, Residential Managers |  |  |  |  |
| Health Educator, Athletic Trainer, Occupational Therapists, Speech Pathologists |  |  |  |  |
| Licensed Mental Health Counselors/Professionals |  |  |  |  |
| Medical Records Technician |  |  |  |  |
| Medical Directors |  |  |  |  |
| Case Managers |  |  |  |  |
| Pharmacists |  |  |  |  |
| Physical Therapists, |  |  |  |  |
| Foster Care Case Manager |  |  |  |  |
| Psychologists, Psychotherapists, Behavioral Analysts |  |  |  |  |
| Nurse Practitioners, |  |  |  |  |
| Psychiatrists |  |  |  |  |
| Psychiatric Nurse Practitioner |  |  |  |  |
|  |  |  |  |  |
| Para-Professional Social Workers / Addiction Interventionists |  |  |  |  |
| Other: Maintenance, Custodial, Security Worker, Drivers, Others: |  |  |  |  |

4. Are the Applicant’s physicians/psychiatrists required to carry ☐ Yes ☐ No

Professional Liability insurance?

a) If Yes, what are the minimum Professional Liability limits required? $\_\_\_\_\_\_\_\_ per occurrence / $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_aggregate

b) Are Applicants physicians/psychiatrists required to provide a certificate of insurance? ☐ Yes ☐ No

5. Does Applicant employ Attorneys? ☐ Yes ☐ No

a) If Yes, in what capacity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Do the Applicant’s employed Attorneys carry their own E&O Insurance? ☐ Yes ☐ No

7. Are there procedures for Pre-Employment Screening? ☐ Yes ☐ No

a) If yes, do they include Reference Checks? ☐ Yes ☐ No

b) Indicate staff In-Services: ☐ Safety ☐ Behavior Management ☐Patient Rights

☐Medical Administration ☐Other:

c) Are staff/volunteers trained in First Aid/CPR? ☐ Yes ☐ No

d) Does the Applicant run criminal background investigations on prospective ☐ Yes ☐ No

employees and volunteers?

i. If Yes, does the Applicant routinely request and receive such ☐ Yes ☐ No

background investigations?

Explain the process:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e) Do volunteers follow the same training and screenings as staff? ☐ Yes ☐ No

8. Does the Applicant verify Employment Related references? ☐ Yes ☐ No

a) If yes, ☐ In Person ☐By Telephone

|  |
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| **SECTION V – POPULATION SERVED** |

Please indicate the population served by the Applicant’s programs (total should equate to 100%).

|  |  |  |  |
| --- | --- | --- | --- |
| Developmentally Disabled | % | Residential Youth | % |
| Alcohol/Drug Rehabilitation | % | Boys & Girls Clubs | % |
| Community Services | % | Big Brothers/Big Sisters | % |
| Medical/Physical Rehabilitation | % | YWCA | % |
| Behavioral Healthcare | % | Headstart/Community Action | % |
| Adoption or Foster Care | % | Other – Describe: | % |

10. Has the Applicant’s policy or coverage been declined, cancelled, or non-renewed ☐ Yes ☐ No

during the last three (3) years? (Missouri Policyholders: Do not complete this answer):

a) If Yes, describe (Missouri Policyholders: Do not complete this answer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION VI – PROPERTY EXPOSURES** |

1. Property Damage Limit Requested

a. Property Damage Deductible Requested

b. Are property damage values at 100% replacement cost? ☐ Yes ☐No

If not, what valuation percentage has been reported?

2. Business Interruption Limit Requested

a. Time Deductible       hours

b. Does the business interruption limit requested represent 12 months of annual business income exposure?

c. If not, what limit has been reported?

3. Extra Expense Limit Requested

4. Total area occupied by the Applicant at all locations?

5. Any machinery breakdown losses in previous 5 years? ☐ Yes ☐No

If Yes, please explain (include description of occurrence, machinery involved and amount of loss/claim):

6. Has the insured ever been refused machinery breakdown coverage in the past? ☐ Yes ☐No

7. Does scheduled maintenance include: Oil Testing ☐ Yes ☐ No Vibration Analysis ☐ Yes ☐ No Infrared Scanning ☐ Yes ☐ No Other ☐ Yes ☐ No

8.  Do you have any locations with Solar Panels?                                               ☐ Yes ☐ No

If yes: a. Do they produce more than 250 KW (per unit)?             ☐ Yes ☐ No

b. Please advise the age of the panels:                                    \_\_\_\_\_\_\_\_\_

c.  For new installations, confirm that systems have arc fault circuit interruption along with residual

current detection.      ☐ Yes ☐ No

d.  How often are systems inspected including thermal infrared scans to look for hot spots at electrical connections.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION VII – UMBRELLA COVERAGE** |

1. If Umbrella coverage is desired over Employer’s Liability, please provide the following primary coverage details:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Carrier:** | **Policy Number:** | **Policy Limits:** | **Effective / Expiration Dates:** | **Premium:** | **Total Annual Payroll** |
|  |  | $      Each Accident  $      Each Policy  $      Each Employee | - | $ | $ |

|  |
| --- |
| **SECTION VIII – LIABILITY AND PROFESSIONAL LIABILITY EXPOSURES** |

2. Does the Applicant have any of the following?

Swimming Pool(s) Diving Board(s) Trampoline(s) Horse(s) Ropes Course(s)

|  |
| --- |
| **SECTION IX – EXPIRING COVERAGE** |

List expiring insurance coverage information (i.e. – Professional & General Liability, Property, Auto, Umbrella, D&O):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Coverage Type**  (Professional Liability, General Liability, Auto Liability, etc) | **Company** | **Claims Made or Occurrence** | **Retroactive Date**  **(for claims made coverage only)** | **Expiration Date** | **Deductible** | **Limit of Liability** | **Annual Premium** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

17. Producer Information:

Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Producer Firm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Where did you hear about the Irwin Siegel Agency?

Advertisement Another Insured Association Referral

Broker Internet Mailing

Telemarketing Call Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION V – FRAUD WARNINGS AND SIGNATURES** |

**NOTICE TO KANSAS APPLICANTS**: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

**NOTICE TO ALL OTHER APPLICANTS:**

**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 information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and MAY subject such person to criminal and civil penalties.**

**DECLARATION AND CERTIFICATION**

**BY SIGNING THIS APPLICATION, THE APPLICANT REPRESENTS TO THE COMPANY THAT, TO THE BEST OF THE APPLICANT’S KNOWLEDGE, ALL STATEMENTS MADE IN THIS APPLICATION AND ANY SUPPLEMENTS AND ATTACHMENTS HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED.**

**THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED.**

**COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT’S ACCEPTANCE OF THE COMPANY’S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.**

**THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS HUMAN SERVICES PROFESSIONAL EXPOSURES.**

|  |  |  |
| --- | --- | --- |
| Signature of Applicant |  | Signature of Broker/Agent |
| Title |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Date |  | Signed by Licensed Resident Agent  (Where Required By Law) |
| Submit Application to:  Irwin Siegel Agency  PO Box 309  Rock Hill, NY 12775  P: (800) 622-8272  F: (845) 796-3661  www.siegel@siegelagency.com |  | Print Name |
|  | License Number |