***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.***

**Instructions**

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:

* General Information Application
* Human Services Supplement Application – Abuse Exposure Evaluation

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| **SECTION I – GENERAL INFORMATION** |

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

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

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| **SECTION II – TREATMENT** |

1. Treatment Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Residential Treatment Program: ☐ Yes ☐ No Number of Beds \_\_\_\_\_\_

3. Outpatient Treatment Program: ☐ Yes ☐ No Number of patients served \_\_\_\_\_\_

4. Are counselors / staff given a minimum of one hour of clinical supervision weekly? ☐ Yes ☐ No

5. Does the Applicant provide any services to people who are incarcerated or recently released from incarceration? ☐ Yes ☐ No

a. If yes, please explain what offenses have been committed by the ex-offender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Does the Applicant have any in-school programs? ☐ Yes ☐ No

a. If yes, please explain the types of programs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

7. Are services to children available? ☐ Yes ☐ No

a. If yes, please explain the types of programs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

8. Does the Applicant provide integrated behavioral health and/or primary medical services? ☐ Yes ☐ No

a. If yes, please explain what services are provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION III – SERVICES OFFERED** |

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| **Service** | **Residential – Number of Beds** | **Number of Annual Outpatient Visit** |
| ☐ Alcohol Dependency | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Drug Addiction | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Eating Disorders | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Co-occurring Disorders | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Relapse Prevention Therapy | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Detoxification (*If yes, please complete the Detoxification Section)* | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Sexual Addiction | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Drug Courts | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Needle Exchange Programs | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| ☐ Methadone Maintenance / Suboxone / Buprenorphine | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_doses |
| ☐ Other | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |

1. Does the Applicant’s facility provide opioid treatment (Methadone Maintenance, LAAM, etc.) ☐ Yes ☐ No

a. If Yes, which agency licenses the program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **SECTION IV – OUTPATIENT FACILITIES/SERVICES** |

1. Please indicate services rendered and annual Out-Patient Visits

**Outpatient Facilities/Services** **Number of Annual Outpatient Visits**

☐ Mental Health Counseling

☐ Family Counseling

☐ Crisis Intervention

☐ Employee Assistance Program

2. Does the Applicant operate a Crisis Hotline? ☐ Yes ☐ No

a. If Yes, how many calls received yearly? \_\_\_\_\_\_\_\_\_\_\_

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| **SECTION V – RESIDENTIAL FACILITIES: (Only if residential services are provided)** |

1. Indicate the age group to whom services are provided: Under 18 \_\_\_\_\_\_ 18-65 \_\_\_\_\_ Over 65 \_\_\_\_\_

2. Does the Applicant have any alternatives to incarceration or locked door facilities? ☐ Yes ☐ No

a. If Yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Is there a written Emergency Evacuation Plan? ☐ Yes ☐ No

4. Is there a written and enforced Smoking Policy? ☐ Yes ☐ No

5. Are any locations licensed as hospitals? ☐ Yes ☐ No

6. Are any of the Applicant’s services provided within a hospital setting? ☐ Yes ☐ No

7. Does the facility meet all applicable Health, Safety and Building codes? ☐ Yes ☐ No

8. What types of medications are used for treatment, if any? Please list (Methadone, Antabuse, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Does the Applicant’s Physician use Buprenorphine to treat opioid addiction? ☐ Yes ☐ No

10. If Yes, has the Physician received a waiver to prescribe buprenorphine for the treatment of opioid addiction? ☐ Yes ☐ No

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| **SECTION VI – DETOXIFICATION SERVICES: (Only if residential services are provided)** |

1. What license level is the detox unit? \_\_\_\_\_\_\_\_\_

2. Are Rapid detox services provided? ☐ Yes ☐ No

a. If so, at which locations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Number of beds per location? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Please provide a breakout of the number of beds and/or OPV’s for each of the following services provided:

|  |  |  |
| --- | --- | --- |
|  | **Number of Beds** | **Number of Annual**  **Outpatient Visits** |
| **Outpatient Detoxification** | | |
| Social Supervised |  |  |
| Medically Supervised |  |  |
| **Residential Detoxification** | | |
| Social Rehabilitation – services provided in a supportive environment with no medication required for withdrawal symptoms. Supervision is provided by appropriately trained staff, emphasis is on peer and social support. |  |  |
| Medically Monitored Withdrawal Services – services in an in-patient or residential setting for persons with mild to moderate withdrawal symptoms where the person has been identified as not being able to abstain due to a situational crisis, past history of withdrawal complications or someone in danger of relapse. A physician's assistant under the supervision of a physician, nurse practitioner, a registered nurse or a licensed practical nurse is required to provide coverage for each shift, seven days per week. |  |  |
| Medically Supervised Withdrawal Services - services must be provided under the supervision and direction of a licensed physician and shall include medical supervision of persons undergoing moderate withdrawal or at risk of moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence. A physician, nurse practitioner and/or physician's assistant under the supervision of a physician must be on staff sufficient hours to perform the initial medical examination and prescribe medications, but not required on staff or on call 24 hours a day. |  |  |
| Medically Managed Detoxification - services for patients whom are acutely ill from alcohol-related and/or substance-related addictions or dependencies, including the need for medical management of persons with severe withdrawal symptoms or risk of severe withdrawal symptoms. This may include individuals with or at risk of acute physical or psychiatric comorbid condition. Services to Individuals who are incapacitated to a degree requiring emergency admission. A physician must be on duty or on call at all times and available within in fifteen minutes if needed. Registered nurses must be immediately available at all times. |  |  |

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| **SECTION VII – POLICIES AND PROCEDURES** |

1. Does a medical professional screen residents prior to admission? ☐ Yes ☐ No

2. Is a physical exam completed within 24 hours of admission? ☐ Yes ☐ No

3. Is the admission assessment conducted by a qualified practitioner? ☐ Yes ☐ No

a. Who is completing the admission assessments?

4. Are there written protocols for admission/triage that are reviewed and updated at least annually?

☐ Yes ☐ No

5. Please describe the procedure which determines who is eligible for admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

6. Is admission Voluntary, Involuntary, Court Mandated, Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you have intake procedures: ☐ Yes ☐ No

8. Does the assessment include a complete mental health evaluation? ☐ Yes ☐ No

9. Please describe the client monitoring procedures for the first 72 hours of admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **SECTION VIII – RAPID RESPONSE/HOSPITALIZATION PROCEDURES** |

1. How are medical emergencies managed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

2. Does the Applicant provide staff training in medical emergency response? ☐ Yes ☐ No

3. Does the Applicant require that staff qualified in emergency response be on duty at ☐ Yes ☐ No

all times?

4. Are staff competencies reviewed at least annually in medical emergency response and in the use of emergency equipment/medications? ☐ Yes ☐ No

5. Is there an on call physician 24 hours/7 days a week? ☐ Yes ☐ No

6. In the event of an emergency, are clients transported to the hospital or Emergency center? ☐ Yes ☐ No

7. Does the Applicant have a formal agreement with a hospital/emergency center for the transfer of clients in need of acute medical or acute psychiatric care? ☐ Yes ☐ No

8. Does the Applicant have discharge procedures? ☐ Yes ☐ No

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

**NOTICE TO ALABAMA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines, or confinement in prison, or any combination thereof.

**NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND & WEST VIRGINIA 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 CALIFORNIA APPLICANTS:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 for the purpose of defrauding or attempting to defraud the 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 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.

**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 of the third degree.

**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 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 MAINE 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 may include imprisonment, fines or a denial of insurance benefits.

**NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 MINNESOTA APPLICANTS:** 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 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.

**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 NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.

**NOTICE 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.

**NOTICE 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.

**NOTICE 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.

**NOTICE TO OREGON APPLICANTS:** WARNING: 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

**NOTICE 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.

**NOTICE TO TENNESSEE, VIRGINIA & 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.

**NOTICE TO VERMONT APPLICANTS**: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**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 MISREPRENSENTED 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.**

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

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| Date  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](http://www.siegel@siegelagency.com) |  | Signed by Licensed Resident Agent  (Where Required By Law) |
|  | Print Name |
|  | License Number |