***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.***

**BY COMPLETING THIS APPLICATION, THE APPLICANT IS APPLYING FOR COVERAGE WITH ACE AMERICAN INSURANCE COMPANY (THE “COMPANY”)**

**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
* Agency Brochures and agency program descriptions

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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 – POPULATION SERVED** |

1. Please indicate the population served based on total annual census:

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| --- | --- | --- | --- |
| **Developmentally Disabled** | **Psychiatric Rehabilitation** | **Medical / Vocational Rehabilitation** | **Youth & Family Services** |
| Intellectual Disabilities: \_\_\_\_\_ | Mental Disabilities: \_\_\_\_\_ | Elderly: \_\_\_\_\_ | Foster Care: \_\_\_\_\_ |
| Autistic: \_\_\_\_\_ | Homeless: \_\_\_\_\_ | Brain Injury: \_\_\_\_\_ | Adoption: \_\_\_\_\_ |
| Cerebral Palsy: \_\_\_\_\_ | Alcohol & Drug: \_\_\_\_\_ | Sports Injury: \_\_\_\_\_ | Juvenile Residential: \_\_\_\_\_ |
| Down’s Syndrome: \_\_\_\_\_ | Methadone Maintenance: \_\_\_\_\_ | Spinal Injury: \_\_\_\_\_ | Headstart: \_\_\_\_\_ |
| Other: \_\_\_\_\_ | Forensic: \_\_\_\_\_ | Disease: \_\_\_\_\_ | Child Day Care: \_\_\_\_\_ |
|  | Juvenile Delinquent: \_\_\_\_\_ | Amputees: \_\_\_\_\_ | Abused Children: \_\_\_\_\_ |
|  | Sexual / Violent Offenders: \_\_\_\_\_ | Other: \_\_\_\_\_ | Abused Adults: \_\_\_\_\_ |
|  | Other: \_\_\_\_\_ |  |  |

1. Does the Applicant provide any services to clients who are currently incarcerated? [ ]  Yes [ ]  No
2. If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Does the Applicant provide any services to clients who were formerly incarcerated? [ ]  Yes [ ]  No
	1. If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does the Applicant have any alternatives to incarceration? [ ]  Yes [ ]  No
	1. If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Does the Applicant have any locked door facilities?
	1. If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Indicate the total percentage of the population served who are under 18 years of age: \_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does the Applicant provide integrated behavioral health and/or primary medical services? [ ]  Yes [ ]  No
	1. If Yes, please explain what services are provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECTION III – PROGRAMS** |

1. Do any programs provide services that have methadone maintenance? [ ]  Yes [ ]  No
	1. If Yes, complete the Methadone Supplemental Application.
2. Please indicate the type of workshop contracts performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please provide payroll for off-site janitorial or landscaping contracts:

Contract: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payroll: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payroll: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please provide receipts of any wholesale/retail business run by Applicant: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you offer telemedicine services to your patients? [ ]  Yes [ ]  No
	1. Please explain the types of services provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. If Yes, how is this service provided, i.e via phone, email, live video chat, etc.?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are telemedicine services provided to your patients only, or is this service provided to third party entities?

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

* 1. If the service is provided to third parties, is there a written agreement in place between both parties?

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

1. Please list which staff members provide telemedicine services, and the services each provides. \_\_\_\_\_\_\_

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

1. Do you offer these services out of your state? [ ]  Yes [ ]  No
	1. If Yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. If Yes, is the clinician providing those services licensed in those states/countries? [ ]  Yes [ ]  No

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| **SECTION IV – RESIDENTIAL FACILITIES** |

1. Indicate the age group to whom the majority of services are provided:

Under 18 \_\_\_\_\_ 18-65 \_\_\_\_\_ Over 65 \_\_\_\_\_

1. What is the average occupancy of the residential facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is the average length of stay?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does the Applicant operate a detox unit? [ ]  Yes [ ]  No
	1. If Yes, how many beds are used for medical detoxification? \_\_\_\_\_\_\_\_\_\_\_\_
	2. What license level is the detox unit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Does a physician screen residents prior to admission? [ ]  Yes [ ]  No
	1. If No, please describe the procedure that determines who is eligible for admission: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Besides alcohol-related traffic offenses, does the applicant’s program include [ ]  Yes [ ]  No

involuntary treatment?

* 1. If Yes, what percentage of your overall population is treated in this program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Describe the program model: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Are residents physically restrained? [ ]  Yes [ ]  No

If yes, are restraints [ ]  Physical [ ] Mechanical [ ]  Chemical Please attach a copy of the restraint policy.

1. Does the Applicant provide education and training on suicide prevention and assessment? [ ]  Yes [ ]  No
2. Do you have facilities for surgery, X-Rays, or other medical treatment? [ ]  Yes [ ]  No

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

1. Is there a written emergency evacuation plan? [ ]  Yes [ ]  No
	1. If Yes, are emergency evacuation procedures and floor plans posted? [ ]  Yes [ ]  No
	2. If Yes, are there at least two exit routes? [ ]  Yes [ ]  No
2. Does the emergency evacuation plan include notification of the fire department? [ ]  Yes [ ]  No
3. How often are fire drills conducted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Is there a written and enforced smoking policy? [ ]  Yes [ ]  No
5. Does the facility meet all applicable health, safety and building codes? [ ]  Yes [ ]  No
6. Does the Applicant provide any hospital based services? [ ]  Yes [ ]  No
	1. If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **SECTION V – OUTPATIENT FACILITIES** |

1. Does the Applicant operate a crisis hotline? [ ]  Yes [ ]  No
2. If Yes, how many calls are received yearly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does the Applicant make telephone referrals? [ ]  Yes [ ]  No
4. If Yes, how many referrals are received yearly?
5. Are child care services available? [ ]  Yes [ ]  No
6. If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Please provide the following information regarding outpatient visits (*Outpatient visits (OPVs) are determined by taking the number of clients multiplied by the number of times they visit the facility.*)

|  |  |
| --- | --- |
| Mental Health Counseling:       | Number of OPVs:       |
| Crisis Intervention:       | Number of OPVs:       |
| Case Management Services:       | Number of OPVs:       |
| Clinic:      Is the clinic open to the public?: [ ]  Yes [ ]  No | Number of OPVs:       |
| Family Counseling:       | Number of OPVs:       |
| Referral Agency | Number of OPVs:       |
| Employee Assistance Program | Number of OPVs:       |
| Substance Abuse Counseling | Number of OPVs:       |
| Special School | Average Number attending daily:       |
| Senior Citizen Day Care | Average Number attending daily:       |
| Camps | Number of campers served:      [ ]  Year Round [ ]  Summer Only |

1. Number of group sessions:      Number of individual contacts:

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| **SECTION VI – 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 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 commits a fraudulent insurance act.

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