HUMAN SERVICE SUPPLEMENTAL APPLICATION

irwin siegel agency
INSURANCE PROGRAMS & RISK MANAGEMENT

Applicant/Organization Name (Named insured as it reads on policy): Federal ID #:

Mailing Address: County:

City: State: Zip:

Phone: Fax: Email:

Website:

Is the Applicant's organization owned by a private equity fund structure? ☐ Yes ☐ No

If yes, provide name of private equity firm:

Operating as: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other:
☐ For Profit ☐ Non-Profit ☐ Govt Facility ☐ Other:

Executive Director: Email:

Contact Person for: Human Resources: Boiler Inspection:
Safety:

Current Operating Budget: Years of Operation:

Annual Budget for each of the past two (2) years:

Primary Funding Source:

Revenue Sources: Donations: % Federal, State, Local Funding: %

Have you ever filed for protection under Chapter 11 or Chapter 7 of Bankruptcy code (title 11 US Code)?: ☐ Yes ☐ No

State Agency(ies) in which license(s) are held:

Expiration dates of current State Licenses: Residential:
Day Programs:
Others:

Are there any Serious Deficiencies noted in most recent Re-Certifications/Compliance Audits?: ☐ Yes* ☐ No
*If yes, please attach list and describe.

1. What state and national Organization(s) or Association(s) are you a member of?:

2. Is your agency accredited? (i.e. CARF, ACO, JCAHO, etc.): ☐ Yes* ☐ No
*If yes, what agency/program, level, and expiration date(s):

3. Does your agency have any Subsidiaries/Holding Corps/Related Organizations with equity interest?: ☐ Yes* ☐ No
*If yes, please list and describe:

4. Does your agency have a Pension/Welfare Plan? ☐ Yes* ☐ No
*If yes, please name:

5. Does your agency act as a Managed Care Organization or Gatekeeper? ☐ Yes ☐ No

6. List Special Events (i.e. Special Olympics, Fundraising, Annual Banquet, etc.):

INSURANCE INFORMATION

1. Has any policy or coverage been declined, canceled, or non-renewed during the last three (3) years?: ☐ Yes ☐ No
   Missouri applicants need not reply
2. Has a lead abatement been performed since 1971?: ☐ Yes ☐ No
3. Have asbestos materials been: ☐ determined **not** to be present ☐ removed, or ☐ protected to prevent flaking
4. Do you have any buildings with EIFS (Exterior Insulation and Finishing Systems)?: ☐ Yes* ☐ No
   *If yes, please provide the address(es) of building(s):

   a. What is the age of the installation?:
   b. What are the qualifications of the installation contractor?:
   c. Describe the maintenance schedule for checking into issues:
5. 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:
6. Do you have any vacant buildings? ☐ Yes ☐ No
   *If yes: a. Location:
   b. How long has the building been vacant?
   C. What are the future plans for the location?
   d. How often is the building checked inside and outside?
7. If umbrella coverage is desired over Workers' Compensation, please provide the following:
   Company: Premium:
   Policy #: Effective/Expiration dates: Limits:
8. Does your agency have any of the following?:
   ☐ Swimming Pool(s) ☐ Diving Board(s) ☐ Trampoline(s) ☐ Horse(s)
9. Do you have any Claims-Made Coverage?: ☐ Yes* ☐ No
   *If yes, which policies?
10. Does your current insurance program provide Abuse/Molestation coverage?: ☐ Yes* ☐ No
    *If yes, what limits?:

Please submit the following with this application:

- A complete ACORD submission must accompany this application
- Please provide five (5) years Hard Copy Loss Runs
- Please include any Agency descriptive or brochures
- A current list of Vehicles must accompany this application
- MVRs on all drivers
- Drivers List
- Driver Eligibility Guidelines
- Schedule of any EDP/Equipment
- Financials, if Agency is For Profit

HUMAN SERVICES PROFESSIONAL LIABILITY APPLICATION

1. Does your current insurance program provide Professional Liability Coverage? ☐ Yes* ☐ No
   *If yes, what limits?:

FOR COMPANY USE ONLY

☐ Occurrence
☐ Claims Made Retro-Date

If you are applying for claims-made coverage, the following important notice applies:
NOTICE: THIS IS A CLAIMS MADE AND REPORTED POLICY. THIS POLICY APPLIES ONLY TO THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED TO THE COMPANY DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.

STAFFING

1. Indicate total staff: Annual Payroll: $ _____ Turnover Ratio: _____

   # of Full Time: ____ # of Part Time: ____ # of Volunteers: ____ # of Board Members: ____

   Please breakout total staff by job duties below:

   Staff Breakout

Full Time	Part Time	Contracted	
			Para-Professional Social Worker / Treatment Coordinator / Treatment Assistant / Peer Support Specialist
			Homemaker / Home Health Nurse / Aide / Sitter / Companion / Direct Support Professional / Bereavement Therapist / Treatment Technician / Certified Nursing Assistant
			Dietitian / Nutritionist / Resident Manager
			LPN / Dental Hygienist / Pharmacy Assistant / Laboratory Technician / EKG or Ultrasound Technician / X-Ray Technician / Radiologist Technician / Certified Medical Assistant / Medical Technician
			Nurse / Dialysis Technician / Enterostomal Therapist
			Social Worker / Therapist / Counselor / Case Manager
			Speech Pathologist / Occupational Therapist
			Medical Director
			Pharmacist
			Respiratory Therapist / Physical Therapist / Phlebotomist / Nuclear Medicine Technician / Radiation Therapist
			Clergy
			Psychologist
			Nurse Practitioner / Physician Assistant
			Paramedic / EMT
			Psychiatrist
			Other: Maintenance, Custodial, Security Worker, Clerical, Administrative, Route Drivers

2. a. Do you have any employed or contracted general medical physicians?: ☐ Yes ☐ No
   b. Do you have any employed or contracted psychiatrists?: ☐ Yes ☐ No
3. a. Are your physicians/psychiatrists required to carry professional liability insurance?: ☐ Yes* ☐ No
      *If yes, what are the minimum limits required?: _____
   b. Are your physicians/psychiatrists required to provide a certificate of insurance annually?: ☐ Yes ☐ No
4. Do you employ Attorneys?: ☐ Yes* ☐ No *If yes, in what capacity?: _____
5. Do your employed Attorneys carry their own E&O insurance?: ☐ Yes ☐ No
6. Indicate staff In-Services: ☐ Safety ☐ Patient Rights ☐ Behavior Management ☐ Medical Administration ☐ Other: _____
7. Does your screening/hiring process include the following?:

Personal Reference Checks	☐ Yes	☐ No	Fingerprinting	☐ Yes	☐ No
Employment Related Reference Checks	☐ Yes*	☐ No	National Child Abuse Registry Checks	☐ Yes	☐ No
*If yes, by telephone?	☐ Yes	☐ No	Primary source verification of licensing/certification	☐ Yes	☐ No
Comprehensive Personal Interviews	☐ Yes	☐ No	Primary source verification of educational status	☐ Yes	☐ No
National Criminal Record Checks (50 State)	☐ Yes	☐ No	Drug Testing	☐ Yes	☐ No

8. Do volunteers follow the same training and screenings as staff?: ☐ Yes ☐ No
9. Do you verify Employment Related references?: ☐ Yes* ☐ No
   *If yes, ☐ In Person ☐ By Telephone
10. Do you conduct a personal interview for each prospective employee?: ☐ Yes ☐ No
11. What is the prior training of the Executive Director?:
    a. Does the Executive Director have knowledge of child welfare issues via prior work experience or relevant educational background?: ☐ Yes ☐ No
    b. Is the Executive Director on site?: ☐ Yes ☐ No
    c. How long has Senior Management been in place?: _____

POPULATION SERVED

1. Indicate the population served by programs:

Intellectually /Developmentally Disabled:	%	Alcohol/Drug Rehab:	%
Community Services:	%	Medical/Physical Rehab:	%
Behavioral Healthcare:	%	Adoption or Foster Care:	%
Residential Youth:	%	CASA:	%
Community Action/Headstart:	%	Child Care:	%
Sexual Offenders:	%		

SEXUAL AND PHYSICAL ABUSE

STAFF

1. Please complete employee grid below:

	Number Employed	Number Contracted	Number Volunteer
All employees with client contact			
All employees without client contact			
Totals			

2. Annual turnover rate:
3. If operations are multi-state, please list the top 5 states where employees are located. List state and number of employees:

CLIENT DETAILS

1. Total number of individual clients/patients/students/members served annually:
2. % of the above that are disabled/handicapped/at risk?
3. Please break down # served annually: Ages 0-10: 11-18: 19-65: 65+:

SCREENING AND SELECTION

1. Does your employment application (paid and volunteer) include questions about whether the individual has ever been convicted/pled guilty to, pled no contest to, or admitted to any crime, but not limited to, sex-related or child abuse-related offenses? Yes No
2. Is a standard application used which includes a signed code of conduct? Yes No
3. Is a face-to-face interview required? Yes No
4. Is there a standard list of interview and reference questions? Yes No
5. Are behaviorally based/open ended interview questions used when screening applicants? Yes No
6. Is there more than one person present during the interview process? Yes No
7. Are personal and professional references required? Yes* No
   *If yes, are they verified? Yes No
8. What types of background screening are completed?

Multi-state criminal background check?	Yes	No	Professional licenses (when applicable)	Yes	No
National sex offender registry check?	Yes	No	FBI fingerprinting?	Yes	No
Social security number trace?	Yes	No	Motor Vehicle Records search?	Yes	No
County criminal records search?	Yes	No	Other, please describe:		

   Does this include any additional counties lived in within the last 7-10 years? Yes No
9. What kind of evaluation is done if an applicant has any criminal convictions?
10. Are background checks repeated for any employee that has regular/routine contact with program participants? Yes* No
    *If yes, how often?
11. In the past 10 years, have there been any staff members or officers that have been terminated for reasons related to abusive behavior? Yes No

SEXUAL AND PHYSICAL ABUSE *(continued)*

TRAINING

1. Is training completed at hire for any employee that works at the organization? ☐ Yes ☐ No
2. Are volunteers trained in the same manner as employees? ☐ Yes ☐ No
3. Is training completed before the employee has access to program participants? ☐ Yes ☐ No
4. Does training include:
   - A review of organizational policies/procedures? ☐ Yes ☐ No
   - How to prevent abuse and/or sexual activity between participants? ☐ Yes ☐ No
   - Abuse reporting requirements and how to report suspicions and concerns? ☐ Yes ☐ No
   - How to recognize signs of abuse in victims? ☐ Yes ☐ No
   - Separate or additional training for supervisors/managers? ☐ Yes ☐ No
5. How often is training repeated? ☐
6. Is training tracked/recorded? ☐ Yes ☐ No
7. Are program participants trained on how to protect themselves from abuse? ☐ Yes ☐ No
8. Are participants and parents/guardians trained on how to report any concerns? ☐ Yes ☐ No
9. Is there education in place to teach participants that are minors about appropriate vs. inappropriate behavior? ☐ Yes ☐ No

MONITORING AND SUPERVISION

1. Is staff required to have program participants within line of sight at all times? ☐ Yes ☐ No
2. Is there a sign-in/sign-out procedure in place for visitors? ☐ Yes ☐ No
3. Are there unobstructed windows within doors to any classrooms or other meeting spaces? ☐ Yes ☐ No
4. Are there procedures in place for any field trips, outings, or overnight stays (if applicable)? ☐ Yes* ☐ No
   *If yes, please explain: ☐
5. Are there written required ratios for staff and program participants? ☐ Yes ☐ No
6. Has a mechanism been developed to ensure that sexual abuse prevention policies and procedures are implemented and enforced throughout the organization? ☐ Yes ☐ No

RESPONDING

1. Is a written procedure in place for reporting any concerns, complaints, and grievances? ☐ Yes ☐ No
   If so, how is it communicated to both employees and volunteers? ☐ Yes ☐ No
   Is there an anonymous reporting method as well? ☐ Yes ☐ No
2. Is a written procedure in place for any applicable mandated reporting requirements? ☐ Yes ☐ No
3. Is a written crisis response plan or incident management plan in place for dealing with staff personnel, victims, parents, authorities, and media if you have an incident of abuse? ☐ Yes ☐ No

GENERAL

Corporal Punishment

1. What is the agency's policy on corporal punishment? ☐ Yes ☐ No
2. Is there a written policy concerning the use of corporal punishment? ☐ Yes ☐ No
3. Have there ever been any claims for corporal punishment? ☐ Yes ☐ No
4. What are the state's laws on corporal punishment? ☐ Allowed ☐ Prohibited
5. Have you ever had an incident which resulted in an allegation of physical or sexual misconduct or abuse? ☐ Yes* ☐ No
   *If yes, how was the matter resolved?
   Was an external investigation completed by an outside agency, authority, accrediting or licensing body? ☐ Yes* ☐ No
   *If yes, who? ☐
   Was a claim made against you? ☐ Yes* ☐ No
   *If yes, please give details:
   Was the case settled? ☐ Yes ☐ No Taken to trial? ☐ Yes ☐ No State investigation completed? ☐ Yes ☐ No
   Results: ☐
   How much money was paid as damages to the victim? ☐

SEXUAL AND PHYSICAL ABUSE *(continued)*

6. Is the applicant aware of any facts, incidents, circumstances, or allegations that may result in claims being made against you? (*If yes, please provide details on a separate sheet of paper) ☐ Yes* ☐ No
7. Has the applicant or any employee/volunteer currently seeking coverage been involved in an allegation or claim relating to sexual abuse or been transferred in or out of your school, branch or corporate location because they were involved, suspected, or a complaint was made regarding an allegation of sexual misconduct? (*If yes, please provide details on a separate sheet of paper) ☐ Yes* ☐ No

SUBMISSION REQUIREMENTS

- 10 years of abuse losses broken out and details of any allegations/incidents/claims.
- 5 years of abuse information which includes carrier, premium, limits, deductibles or SIR.

CLAIMS DETAILS

SAFETY AND RISK MANAGEMENT

1. Does your agency have procedures for Incident Reporting? ☐ Yes ☐ No
   a. Is staff made aware of Incident Reporting Procedures? ☐ Yes ☐ No
   b. Are your program participants instructed on how to report incidents? ☐ Yes ☐ No
   c. Does your agency have an active committee that reviews incidents? ☐ Yes ☐ No
2. Do you have Policies & Procedures in place for Prescribing/Administering Medication? ☐ Yes ☐ No
   a. Who prescribes/administers medications?
   b. Are Non-FDA drugs prescribed or administered? ☐ Yes* ☐ No
      *If yes, please explain:
   c. Where and how are drugs stored?
3. Do the following written plans or protocols exist:
   Emergency evacuation plan including monthly drills? ☐ Yes ☐ No
   Maintenance plan for fire extinguishers and smoke detectors? ☐ Yes ☐ No
   Written fire safety program including documented weekly inspections? ☐ Yes ☐ No
   Child release protocol? ☐ Yes ☐ No
   Child/sexual abuse prevention program including training? ☐ Yes ☐ No
   First aid/CPR training? ☐ Yes ☐ No
   Written playground safety program including documented weekly inspections? ☐ Yes ☐ No
   Do you limit access to your facility via card or code access? ☐ Yes ☐ No
   Do you require signing of roster by both parent and staff at drop-off and pick-up time? ☐ Yes ☐ No
   Do you have a monitoring system (e.g., cameras) in your facility? ☐ Yes ☐ No
   Do you maintain medical history and immunization records on all children? ☐ Yes ☐ No
   Do you obtain signed releases for emergency medical treatment? ☐ Yes ☐ No
   Do you have a policy on drug and alcohol use/abuse? ☐ Yes* ☐ No
   *If yes, please describe:
   Do you have a written and enforced no smoking policy? ☐ Yes ☐ No
   Does your criteria for qualifying drivers include safety training and observation of driving skills? ☐ Yes ☐ No
   Do you have a driver safety program? ☐ Yes ☐ No
   Is Driver Training provided? ☐ Yes ☐ No
   Are seat belts required to be worn by all occupants? ☐ Yes ☐ No

Please complete the appropriate sections that apply.

RESIDENTIAL

Not Applicable ☐

1. Residents age groups (Give number for each): Under 18: ☐ 18-65: ☐ Over 65: ☐
2. a. Do you provide any services to people that are incarcerated or recently released from incarceration? ☐ Yes* ☐ No
   *If yes, please explain:
   b. Do you have any alternatives to incarceration or locked door facilities? ☐ Yes* ☐ No
   *If yes, please describe:
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 or hospital based? ☐ Yes ☐ No
6. Does the facility meet all applicable Health, Safety and Building Codes? ☐ Yes ☐ No
7. What is the client to staff ratio?
8. Is there 24/7 staff? ☐ Yes ☐ No
   a. Are overnight staff in awake positions? ☐ Yes ☐ No

Policies and Procedures

1. Does a physician screen prior to admission of residents? ☐ Yes ☐ No
2. Please describe the procedure which determines who is eligible for admission:
   Is admission Voluntary, Court Mandated, Other:
3. Emergency Services: How are medical emergencies managed?
4. Are staff competencies reviewed at least annually in medical emergency response and in the use of the emergency equipment/medications? ☐ Yes ☐ No

DEVELOPMENTAL DISABILITIES

Not Applicable ☐

1. Population Served: *Actual numbers*

	Developmentally Disabled:	***Other:***	
Intellectual/Developmental			
Autistic			
Cerebral Palsy			
Down Syndrome			

   a. Indicate percentage of population served that is under 18 years of age:
2. Please provide the following information for the applicant's Vocational Exposures:

Off-site Janitorial:	# Contracts:		Annual Payroll:	$
Off-site Landscaping:	# Contracts:		Annual Payroll:	$
Restaurant/Cafeteria:	Type:		Annual Receipts:	$
Stores:	Type:		Annual Receipts:	$
Document Destruction (shredding):	Type:		Annual Receipts:	$
Other:	Type:		Annual Receipts:	$
Other:	Type:		Annual Receipts:	$

   a. Indicate the type of work performed at on-site workshops:
   b. Do you provide Workers' Compensation for workshop employees? ☐ Yes ☐ No

COMMUNITY ACTION/HEADSTART AGENCIES

Not Applicable

1. Does your agency provide any of the following programs or services?
   a. Weatherization/Construction? ☐ Yes ☐ No
      Type of work performed:
      If not contracted, please advise annual payroll amount for weatherization performed by insured:
      Contract cost of subcontracted work:
      Is the contractor required to carry $1,000,000 liability coverage? ☐ Yes ☐ No
      Is the insured added as additional insured on the contractor's policy? ☐ Yes ☐ No
      Is there a hold harmless in favor of the insured? ☐ Yes ☐ No
      Does the insured receive proof of above? ☐ Yes ☐ No
   b. Meals on Wheels? ☐ Yes ☐ No
      Number of meals delivered annually: Annual receipts:
      How are perishables protected?
   c. Food Bank? ☐ Yes ☐ No
      Annual food distribution sales:
   d. Foster Grandparent Program? ☐ Yes ☐ No
      Number of volunteer Grandparents: Number of participants/children:
      Does the volunteer intake process include interviews, criminal background checks, personal references checked, and home visit assessment? ☐ Yes ☐ No
   e. Home Maker Program? ☐ Yes ☐ No
      Total number of participants: Total Payroll:
      Describe services provided:
      Are Medical services provided? ☐ Yes ☐ No
      Low Income Home Energy Assistance Programs? ☐ Yes ☐ No
      Community Service Block Grant Programs? ☐ Yes ☐ No
      Community Development/Economic Development Programs? ☐ Yes* ☐ No
      *If yes, please describe:
      Habitational Programs:

Alcohol/Drug	☐ Yes	☐ No	Transitional Housing	☐ Yes	☐ No
Homebuyer Assistance Programs	☐ Yes	☐ No	Women's Shelter	☐ Yes	☐ No
Homeless Shelters	☐ Yes	☐ No	Youth Residential	☐ Yes	☐ No
Rental Units/Low Income Housing	☐ Yes	☐ No	Other, please describe:		

Head Start Agencies

1. Are Day Care Services provided at any of your facilities? ☐ Yes ☐ No
2. Do you provide home based services? ☐ Yes* ☐ No
   *If yes, please provide total number of participants:
3. Are special needs children cared for? ☐ Yes* ☐ No
   *If yes, how many?
   Are any staff trained to care for these children? ☐ Yes ☐ No
   Please explain:
   Are physical therapy services provided? ☐ Yes* ☐ No
   *If yes, does the contracted professional provide you with a Certificate of Insurance? ☐ Yes ☐ No
4. Do your playgrounds meet all safety requirements of the Consumer Product Safety Committee? ☐ Yes ☐ No
   Are they fenced in? ☐ Yes ☐ No
   Is there any equipment over 6 feet? ☐ Yes ☐ No
   What safety material is used around the playground equipment and what is the depth of the material?

COMMUNITY ACTION/HEADSTART AGENCIES *(continued)*

6. Are there pets at any of your facilities? ☐ Yes* ☐ No
   *If yes, please describe:
7. Does your facility have video cameras installed to monitor all daily activities? ☐ Yes ☐ No
8. Does your facility have an emergency evacuation plan posted? ☐ Yes* ☐ No
   If yes, is the evacuation plan practiced? ☐ Yes ☐ No
   *If yes, how often?
9. Number of field trips conducted each year: Minimum age of child to participate:
   Do you obtain a release from parent/guardian for each trip? ☐ Yes ☐ No
   Are staff to child ratios maintained or increased for field trips? ☐ Yes ☐ No
   Are all children required to wear an identification badge on field trips? ☐ Yes ☐ No
   Are overnight trips conducted? ☐ Yes ☐ No
   Please describe types of field trips:
10. Do you carry a separate Accident Medical Policy? ☐ Yes ☐ No
11. Please provide the following information per location. Attach a separate schedule if necessary.

Location #	Licensed Capacity	Current Enrollment	Staff/Child Ratio	Day Care? Y/N	Special Needs? Y/N	Playgrounds? Y/N
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

BOYS AND GIRLS CLUBS/YWCA

Not Applicable

General Information

1. Type of Program:
   - ☐ Boys & Girls Club - Please also complete **Boys & Girls Clubs** section of this application below
   - ☐ YWCA - Please also complete **YWCA** section of this application below
2. Do you accept adjudicated youth or adults as volunteers? ☐ Yes ☐ No
3. Do you accept adjudicated youth in your programs? ☐ Yes ☐ No
4. Are all visitors required to sign in and out of the facility? ☐ Yes ☐ No
5. Do you carry a separate Accident Medical policy for participants/members? ☐ Yes ☐ No

Boys & Girls Clubs

1. Number of Participants: ☐
2. Do you take participants on field trips or travel? ☐ Yes* ☐ No

   *If yes, please complete the following:

   a. Do any trips involve overnight stays? ☐ Yes* ☐ No

      *If yes, specify duration, destination(s), and purpose: ☐

   b. Number of trips sponsored each year: ☐

   c. Are all trips within the United States? ☐ Yes ☐ No*

      *If no, please specify where trips are taken: ☐

   d. What is the ratio of staff to participants during trips? ☐

   e. Are signed permission and waiver agreements obtained from parent(s) for all trips? ☐ Yes ☐ No

   f. Is there a formal policy regarding emergencies and trained personnel on all trips? ☐ Yes ☐ No
3. Is a permission/release form required for participants in athletic activities? ☐ Yes ☐ No
4. Please check all activities offered:

☐ Archery	☐ Football (touch or flag)	☐ Rugby
☐ Baseball	☐ Go Karts	☐ Scuba Diving
☐ Basketball	☐ Gymnastics	☐ Skating
☐ Bicycle Trips	☐ Hiking/Backpacking	☐ Skateboarding
☐ Boxing	☐ Ice Hockey	☐ Soccer
☐ Ceramics/Pottery	☐ Martial Arts	☐ Softball
☐ Cheerleading	☐ Motorbikes/ATVs	☐ Swimming
☐ Cross Country Track	☐ Mountain Biking or BMX	☐ Trampoline
☐ Diving	☐ Paintball	☐ Woodworking
☐ Field Hockey	☐ Rocketry, Model Rockets	☐ Wrestling
☐ Football (tackle)	☐ Roller Skating/In-Line	

   - ☐ Other unique activities, please describe: ☐

YWCA

1. Please indicate number of members: ☐
2. Please indicate population served under the age of 18: ☐ %
3. Services offered (check all that apply):

☐ Adult Day Care	☐ Day Camp	☐ Overnight Camp
☐ Babysitting	☐ Fitness Center	☐ Shelters (Women, Children, Homeless)
☐ Child Day Care	☐ Fitness Classes	☐ Youth Recreation
☐ Counseling Services	☐ Pools	

   - ☐ Other, please describe: ☐
4. Do you rent or lease your facility to outside entities? ☐ Yes* ☐ No

   *If yes, please complete the following:

5. Do you obtain a Certificate of Insurance with liability limits of at least $1 million? ☐ Yes ☐ No
6. Is a written lease required for every rental? ☐ Yes ☐ No

FRAUD STATEMENTS

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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, NEW MEXICO AND 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 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 AUTHORITIES.

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 PREPARED 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 MATERIAL 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 LOUISIANA 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 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: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

FRAUD STATEMENTS *(continued)*

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 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 (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH 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 AND 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.

SIGNED: _____
(Applicant)

DATE: _____

TITLE: _____
(must be signed by authorized officer)

ORGANIZATION: _____
(Organization's Seal)

SIGNED: _____
(Agent)

DATE: _____

TITLE: _____
(Agent)

ATTEST: _____

PRODUCER: _____

LICENSE NUMBER: _____

ADDRESS: _____

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