



**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.

**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 Budget 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 (title 11 US Code)?  Yes  No
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 interest?  Yes  No  
 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): \_\_\_\_\_  
 \_\_\_\_\_

**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?  Yes  No  
 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

**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 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. Are you enrolled in a state notification system for drivers?  Yes  No
4. Does Applicant lend/lease its vehicles to other agencies?  Yes  No  
 If yes, please describe: \_\_\_\_\_

5. Does Applicant transport anyone other than agency clients? (i.e., Public/School/Seniors)  Yes  No  
If yes, please describe: \_\_\_\_\_

6. Do any staff members use their own vehicles on a regular basis for agency business?  Yes  No  
If Yes, please indicate how many: \_\_\_\_\_  
If No, please skip to question #10.

7. Do any staff members use their own vehicles to transport clients?  Yes  No  
If Yes, please indicate how many: \_\_\_\_\_  
If No, please skip to question #10.

8. Does Applicant require employees to provide certificates of insurance verifying personal automobile coverage?  Yes  No

9. Does Applicant require employees to carry liability insurance at the state required minimum amount?  Yes  No

10. 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: \_\_\_\_\_

11. Does Applicant have drivers over the age of 65?  Yes  No

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

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

14. 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: \_\_\_\_\_

**IV. Staffing**

1. Please indicate total staff:

**# of Full Time:** \_\_\_\_\_ **# of Part Time:** \_\_\_\_\_ **Turnover Ratio %:** \_\_\_\_\_ **# of Board Members:** \_\_\_\_\_ **# of Volunteers:** \_\_\_\_\_

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

3. Exposure count by Classification:

Classification	Employed	Contracted
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	<b>Full – Time</b>	<b>Part-Time</b>	<b>Full – Time</b>	<b>Part-Time</b>
Homemakers, Home Health Nurse Aides, Sitters, Companions, Clerical, Administrative, Bereavement Therapists	_____	_____	_____	_____
Dieticians / Nutritionists	_____	_____	_____	_____
LPNs, Dental Hygienists, Pharmacy Assistants, Lab Technicians, EKG-Ultrasound Tech, Med Tech, Echocardiogram Tech, X-Ray Technicians, Radiology Technician, Certified Medical Technicians	_____	_____	_____	_____
Nurses, Enterstomal Therapists, Social Workers, Dialysis Technicians, Addiction Counselors	_____	_____	_____	_____
Occupational Therapists, Speech Pathologists	_____	_____	_____	_____
Licensed Mental Health Counselors/Professionals	_____	_____	_____	_____
Medical Directors	_____	_____	_____	_____
Pharmacists	_____	_____	_____	_____
Physical Therapists, Respiratory Therapists, Phlebotomists, Clergy, Nuclear Medicine Technicians, Radiation Therapists	_____	_____	_____	_____
Psychologists	_____	_____	_____	_____
Nurse Practitioners, Physician Assistants, EMT	_____	_____	_____	_____
Psychiatrists	_____	_____	_____	_____
Physicians other than Psychiatrists	_____	_____	_____	_____
Para-Professional Social Workers / Addiction Interventionists	_____	_____	_____	_____
Other: Maintenance, Custodial, Security Worker, Route Drivers	_____	_____	_____	_____

4. Are the Applicant's physicians/psychiatrists required to carry Professional Liability insurance?  Yes  No
- 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 employees and volunteers?  Yes  No
- i. If yes, does the Applicant routinely request and receive such background investigations?  Yes  No

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

9. 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 during the last three (3) years? (Missouri Policyholders: Do not complete this answer):  Yes  No

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

11. Are property values at 100% replacement cost?  Yes  No

12. 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		\$ _____	\$ _____

13. Does the Applicant's current insurance program provide Professional Liability Coverage?  Yes  No

a) If yes, provide the limit of liability. \$ \_\_\_\_\_ each occurrence/ \$ \_\_\_\_\_ aggregate

14. Does the Applicant's current insurance program provide Abuse/Molestation coverage?  Yes  No

a) If yes, provide the limit of liability. \$ \_\_\_\_\_ each occurrence/ \$ \_\_\_\_\_ aggregate

15. Does the Applicant have any of the following?

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

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

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

Liability, etc)			only)				

17. Producer Information:

Contact Name \_\_\_\_\_ Producer Firm: \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_

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

- Advertisement
- Broker
- Telemarketing Call
- Another Insured
- Internet
- Other \_\_\_\_\_
- Association Referral
- Mailing

**V. 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 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 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 MEDICAL PROFESSIONAL EXPOSURES.

_____ Signature of Applicant	_____ Signature of Broker/Agent
_____ Title	_____ Date
_____ Date	_____ Signed by Licensed Resident Agent (Where Required By Law)
	_____ Print Name
	_____ License Number