

SOCIAL SERVICE AGENCY APPLICATION

FOR OFFICE USE ONLY – Please do not complete.

- | | |
|--|---|
| <input type="checkbox"/> United National Insurance Company | <input type="checkbox"/> Diamond State Insurance Company |
| <input type="checkbox"/> United National Specialty Insurance Company | <input type="checkbox"/> United National Casualty Insurance Company |

All questions must be completed to enable us to provide you with a quote. Please include any brochures or descriptive materials that may assist us in a better understanding of your agency.

YOUR AGENCY

1. The precise name of your agency including any "D/B/A's" _____
 For Profit Non-Profit Other Describe _____

2. Your mailing address: _____
City and State _____ Zip _____
Effective Date of Coverage: _____ Webpage address: _____

Please provide the addresses of all locations owned/leased by the insured to be covered:

STREET ADDRESS CITY AND STATE ZIP CODE OCCUPANCY/EXPOSURE

- (1) _____
(2) _____
(3) _____
(4) _____

3. Please provide a brief description of your operations.

4. How long has your agency been in operation? _____ What is your annual budget? _____

a. Name all subsidiary companies/locations and other operations within applicant's control. _____

b. Has applicant sold, acquired or discontinued any operations in the last 5 years? If yes, explain. _____

5. Please give a complete percentage breakdown of your funding sources (total to equal 100%).

6. Of what organizations or associations are you a member? (Please avoid use of acronyms)

7. Are you aware of any state, federal, local code or professional ethics violations by your agency or any of your employees?

Yes No

8. a. Does your state permit you to do criminal background investigations on prospective employees/volunteers?

Yes No

b. If yes, do you routinely request and receive such background investigations?

Yes No

c. Do you verify employment related references?

Yes No

d. Do you verify educational requirements?

Yes No

e. Do you conduct a personal interview?

Yes No

f. Are licenses checked for employees/volunteers, when appropriate?

Yes No

9. a. Do you discuss at staff orientation, physical and sexual abuse issues, how to recognize the signs and what to do if a client reports someone abused him/her? Yes No
 b. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients? Yes No
 c. Do you have a crisis management plan for dealing with staff, victim, parents, authorities and media if you have an incident of abuse? Yes No
 d. Have you ever had an incident that resulted in an allegation of sexual abuse? Yes No
 If yes, was a claim ever made against you? Yes No
 (If yes, please give details on a separate sheet of paper including the date of the incident and any action taken by management to prevent from occurring again.)
10. Do you maintain training programs for your staff? Yes No
 Describe training offered _____

YOUR OPERATIONS

11. PLEASE CHECK **YES** or **NO** TO THE SERVICE(S) BELOW THAT BEST DESCRIBE YOUR OPERATION.

a. RESIDENTIAL CARE

Do you operate any Residential Facilities? Yes No

(If "Yes", please complete a Residential Facility Questionnaire APA-160 for each facility.)

b. OUTPATIENT SERVICES

Provide annual number of appointments for the following services (each client's visit should be counted as an appointment) Include location no.:

YES	NO		No. of Appts	Loc No.
<input type="checkbox"/>	<input type="checkbox"/>	Drug & Alcohol Treatment: Individual	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug & Alcohol Classes (DUI/DWI)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling: Individual	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling: Group	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	MR Treatment Center	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy Center	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rehabilitation Agency	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Case Management (MH/MR/Comm. Support)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Training	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospice (outpatient)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Family Skills Training	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Independent Living Skills Training	_____	_____ on site
			Loc No. _____	_____ off site

c. Provide number of clients/children per day and number of days per year that facility operates and at what location:

YES	NO		No. per day	No. of clients per year	No. of days	Loc
<input type="checkbox"/>	<input type="checkbox"/>	Before & After School Care	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headstart Program	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Well Child Day Care	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Camps for Mentally Ill or Developmentally Disabled	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Care for Mentally Ill or Dev. Dis. Sheltered Workshop/Work Activity	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recreation Program	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Schools	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	*Agencies for Aging/Senior Citizens	_____	_____	_____	_____

*If yes, please describe the service provided for Agencies for Aging/Senior Citizens _____

d. Foster and/or Adoption Placement Agency Loc No. _____

(If "Yes", please complete attached Foster/Adoption Placement Supplement APA-161.)

e. Home Care _____ Home Health Care _____ Respite Care _____ Loc No. _____
 Age Range of Clients (please enter the number of clients in each age group):
 Level of Care: Developmentally Disabled 0-17 _____ 18-60 _____ 60+ _____
 Mentally Impaired 0-17 _____ 18-60 _____ 60+ _____
 Other _____

Please describe services provided _____

f. Methadone Maintenance Clinic No. of Licensed Slots: _____ Loc No. _____
 g. Meals on Wheels No. of Meals Annually: _____ Loc No. _____
 h. Hotline Center No. of Calls Annually: _____ Loc No. _____
 i. Referral Agency No. of Referrals Annually: _____ Loc No. _____
 j. CASA(Court Appointed Special Advocates) No. of Cases Assigned Annually: _____ Loc No. _____
 k. Mentorship No. of Matches: _____ Loc No. _____
 Center based _____ Off-site based _____ How often do they meet? _____ Loc No. _____
 l. Advocacy Services No. of Clients Served: _____ Loc No. _____
 m. Other Services not described above Annual Client Contacts of Appointments: _____ Loc No. _____
 _____ Loc No. _____
 _____ Loc No. _____

12. STAFF	Employees		Non-Employees (Volunteers/Consultants)	
	No. Full time	No. Part Time	No. Full time	No. Part Time
RN'S/LPN'S	_____	_____	_____	_____
Physicians Assts	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
If any Psychologists, are you requesting primary or excess coverage?	_____			
Others (specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____

13. EMPLOYED OR CONTRACTED PHYSICIANS AND PSYCHIATRISTS

Do you want coverage for employed or contracted Physicians and Psychiatrists? Yes No
(If yes, complete the attached Physicians and Psychiatrists Liability Questionnaire APA-171.)
 If yes, have you verified the credentials of the Physician(s) and/or Psychiatrist(s) that you are requesting coverage for?
 Yes No
 If excess coverage is being requested, have you verified other insurance? Yes No

14. Do you provide any primary medical or skilled nursing services? Yes No If yes, please explain.

15. Do you or any of your staff prescribe any medications? Yes No If yes, **please provide a list** on a separate sheet of paper of the medications, who prescribes them, for what purpose, and how they are secured.

16. Do you contract with any other facilities for additional beds? Yes No If yes, please indicate the number or estimated number of beds and provide a copy of the contract. No. of beds _____

17. Does your agency recommend release, parole or incarceration of clients? Yes No
 (If yes, please explain on a separate sheet of paper.)

18. Do you treat any sexual offenders? Yes No
 (If yes, please explain on a separate sheet of paper.)

19. Do you service clients recently released from a lock-up facility? Yes No
 (Describe the nature of offenses on a separate sheet of paper.)

20. Are you licensed by the state(s) in which you operate? Yes No If No, is a license required? _____
 (Please attach a copy of license and latest inspection)
 If yes, is it renewed annually semi-annually other _____
 Has your license ever been suspended or revoked? Yes No
 If yes, please give details. _____

ADDITIONAL INSURED(S) (PROFESSIONAL LIABILITY)

Name: _____ Insurable Interest - Check box that applies
 Funding/Grant Contract/Services Other
 Address: _____ Describe: _____

Name: _____ Funding/Grant Contract/Services Other
 Address: _____ Describe: _____

Name: _____ Funding/Grant Contract/Services Other
 Address: _____ Describe: _____

Name: _____ Funding/Grant Contract/Services Other
 Address: _____ Describe: _____

COMMERCIAL GENERAL LIABILITY

21. Would you like to include Commercial General Liability coverage? Yes No
 (If yes, please complete the following section and also attach a completed Acord General Liability Application.)

LOCATION NO.	1	2	3	4
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq ft)				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Heat Sensors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Smoke Detectors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
f. Fire Escapes or Exits	No.	No.	No.	No.
g. YEAR OF UPDATES IN CONSTRUCTION	Year:	Year:	Year:	Year:
Plumbing	Yes No	Yes No	Yes No	Yes No
Wiring	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

22. Do you lease or sub-lease to others any portion of the locations listed above? Yes No
If yes, do you require that your tenant carry liability insurance for the occupancy? Yes No
If yes, how often do you make sure the coverage is maintained? _____

23. Are there any pools at any of your locations? Yes No If yes, how many? _____ Loc No. _____
Are there spas or hot tubs at any of your locations? Yes No If yes, how many? _____ Loc No. _____
Are they used exclusively by your clients and/or staff? Yes No If no, describe the uses: _____

Are they secured when not in use? Yes No Please describe security: _____

Are clients supervised while using the pool and/or spa? Yes No Please describe methods: _____

24. Is any construction or carpentry work done for clients or other parties? Yes No

(If Yes, please provide on a separate sheet, a detailed description of the work being performed.)

25. Will you be organizing or sponsoring any fundraising or special events during the next year? Yes No

If yes, please describe each event, including your role and the estimated amount of receipts:

_____ \$ _____
_____ \$ _____
_____ \$ _____

26. Do you participate in or supervise any sports activities for your clients? Yes No

If yes, please describe: _____

COMMERCIAL PROPERTY

27. Would you like to include Commercial Property coverage? Yes No

(If yes, please complete the following section and also attach a completed Acord Property Application.

Note: Please photocopy this Commercial Property Section and complete for additional locations.)

a. What is your total Building value for all locations? _____

b. What is your total Business Personal Property value for all locations? _____

28. Is cooking allowed in each room? Yes No

29. Is there a central eating area? Yes No

30. Is there an adequate number of smoke detectors in public areas and in all living units and fire extinguishers located in easily accessible areas? Yes No

31. Do the smoke detectors and fire extinguishers have annual maintenance and certification? Yes No

32. Are there electrical powered smoke detectors? Yes No

33. Is all wiring with circuit breakers? Yes No

34. Are any buildings vacant, unoccupied, under renovation or under construction? Yes No

If yes, please explain _____

35. Are all buildings designed for present occupancy? Yes No

36. Are there any outstanding NFPA recommendations? Yes No

37. Do all exterior doors have dead bolts and windows with adequate locks? Yes No

38. Is this a non-smoking facility? Yes No

If no, where is the smoking area located _____

If no, is there a designated area for smoking and where is this area located? Yes No _____

39. Is the premises clean, neat and well lit? Yes No

40. Are any of the buildings used for low income housing, refugee facility or retail outlet? Yes No

NON-OWNED AUTO LIABILITY

(Please complete attached Non-Owned Auto Questionnaire APA-162.)

YOUR MOST RECENT INSURANCE HISTORY

LINE	COMPANY	LIMITS	PREMIUM	DED	EXPIRATION DATE	RETROACTIVE DATE
Professional Liability						
General Liability						
Excess and/or Umbrella						
Property/IM/ Crime						

41. If you have not purchased coverage before, please explain. _____

42. Is your expiring professional liability and/or general liability coverage on a claims made basis? Yes No

If yes, would you like us to include prior acts coverage? Yes No

If yes, please provide proof of uninterrupted claims made coverage since the retroactive date.

43. Has any carrier cancelled or refused coverage for your agency? Yes No

(THIS QUESTION DOES NOT APPLY TO APPLICANTS IN MISSOURI)

If yes, please explain. _____

CLAIM INFORMATION

45. Have you had any claims and/or circumstances that have not been previously reported? Yes No

If yes, please attach detailed claim information with the date of the loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.

Please attach 5 years loss history for all coverages requested.

46. Please describe your procedures when reporting potential incidents to the proper authorities. _____

PLEASE READ THE FOLLOWING CAREFULLY

VIRGINIA, TENNESSEE FRAUD STATEMENT

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.

ARIZONA FRAUD STATEMENT

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS FRAUD STATEMENT

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.

CALIFORNIA FRAUD STATEMENT

For your protection, California law requires that you be made aware of the following: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO FRAUD STATEMENT

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.

DISTRICT OF COLUMBIA FRAUD STATEMENT

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.

IDAHO FRAUD STATEMENT

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

INDIANA FRAUD STATEMENT

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY FRAUD STATEMENT

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.

LOUISIANA FRAUD STATEMENT

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.

MAINE FRAUD STATEMENT

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.

MINNESOTA FRAUD STATEMENT

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE FRAUD STATEMENT

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.

NEW JERSEY FRAUD STATEMENT – APPLICATION

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO FRAUD STATEMENT

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.

OHIO FRAUD STATEMENT

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.

Did you remember to?

If you are requesting Professional Liability coverage:

- Complete the Professional Liability Section of this application

If you are requesting General Liability coverage:

- Complete an Acord General Liability Application
 Complete the General Liability Section of this application

If you are requesting Property coverage:

- Complete an Acord Property Application
 Complete the Property Section of this application

If you are requesting Non-Owned Auto coverage:

- Complete the Non-Owned Auto Questionnaire

General Reminders:

- Did you complete each question in all applicable sections as we cannot offer a quote based on incomplete information?
 Did you sign and date all applications?
 Did you attach current loss runs?