



NON PROFIT SOCIAL SERVICE ORGANIZATION APPLICATION

All questions must be answered and application must be signed by applicant.

A. General Information

Applicant - list all entities and operation/interest of each (attach brochure)

Mailing Address _____

Contact Person and Phone Number _____ (____) _____

Effective Date Requested: From _____ To _____

Do you provide service(s) for:

- | | | | |
|--|--|--|--|
| a. Crisis Intervention (Suicide hot lines)? | Yes <input type="checkbox"/> No <input type="checkbox"/> | i. Do you have any contractual agreements holding others harmless or in favor of others? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| b. Overnight facilities for residents? primarily under 18 years old? | Yes <input type="checkbox"/> No <input type="checkbox"/> | m. Leasing or rental of medical equipment? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. Foster care/adoption proceedings? | Yes <input type="checkbox"/> No <input type="checkbox"/> | n. Child Day Care Center? If yes, complete Section G. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. Ambulance/first aid operations? | Yes <input type="checkbox"/> No <input type="checkbox"/> | o. Adult Day Care Center? If yes, complete Section H. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| e. Residential ex-mental patients? | Yes <input type="checkbox"/> No <input type="checkbox"/> | p. Institutional Care Liability? If yes, complete Section I. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| f. Birthing Center? | Yes <input type="checkbox"/> No <input type="checkbox"/> | If Yes to any of the above, please explain (add separate sheet if necessary): _____ | |
| g. Legal matters? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| h. Home health care? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| i. Residential abused/battered women or children? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| j. Ex offenders (criminal or sexual) | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| k. Invasive medical procedures or care? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |

B. History

How long has the applicant been in business? _____

Date organized as a Non Profit: _____ By what authority licensed? _____

License number _____ Expiration Date _____

Has license ever been revoked? Yes No If Yes, why? _____

Current Carrier: _____ Limits: _____

Premium: _____ Policy Term: _____

Has any insurer ever cancelled, declined or refused to renew any policy of insurance? Yes No

If Yes, please explain: _____

Have any claims, suits or incidents for such insurance been made against any applicant in the last five years? Yes No If Yes, please explain: _____

C. Coverage and Limits

<u>Coverage Available</u>		<u>Limits of Insurance</u>
<input type="checkbox"/> COMMERCIAL GENERAL LIABILITY	\$	- Each Occurrence
\$1Mil/\$3Mil Maximum Limit	\$	- Personal and Advertising Injury
	\$	- Fire Damage
	\$	- Medical Expenses (any one person)
	\$	- Products/Completed Operations
		Aggregate Limit
<input type="checkbox"/> SOCIAL SERVICE	\$	- General Aggregate Limit
PROFESSIONAL LIABILITY	\$	- Each Professional Incident
\$1Mil/\$3Mil Maximum Limit	\$	- Aggregate Limit
<input type="checkbox"/> MOLESTATION OR ABUSE INSURANCE	\$	- Each Claim
\$1Mil/\$1Mil Maximum Limit	\$	- Aggregate Limit
<input type="checkbox"/> EMPLOYEE BENEFITS LIABILITY	\$	- Each Claim
\$1Mil/\$1Mil Maximum Limit	\$	- Aggregate

D. General Liability - Exposures

Please list all locations owned, leased, rented or controlled by any applicant:

	<u>Address</u>	<u>Sq. Ft. Occupied</u>	<u>Owned, Leased/Rented</u>	<u>Occupancy</u>
Loc.#1				
Loc.#2				
Loc.#3				
Loc.#4				

Add separate sheet if space is inadequate.

If any other of the following classes apply, please provide payroll for each:

	<u>Payroll</u>
a. Independent Living (nonresidential) - please state payroll for homemakers, aides, nurses or other "in home" services provided.	_____
b. Hospice-Non Residential - same as above.	_____

If Sheltered Workshops, list type of work performed: _____

Any locations rented to others? Yes No If Yes, please state locations: _____

Do you use the services of independent contractors to perform any services? Yes No If Yes, please describe below:

<u>Type of Service</u>	<u>Number of Independent Contractors</u>	<u>Annual Contract Cost</u>
_____	_____	_____
_____	_____	_____

Do you require evidence of insurance from independent contractors? Yes No

If Yes, please state types of insurance required: _____

Are volunteers listed and covered under your Worker's Compensation Policy? Yes No

Are all potential employees and volunteers cleared through the appropriate state and federal agencies for past criminal or abuse/molestation history? Yes No If No, please explain: _____

Please describe any sponsored fund raising events:

<u>Type</u>	<u>Date</u>	<u>Expected Attendance</u>	<u>Location</u>	<u>Description</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

E. Professional Liability

Approximate Number of Clients (persons): _____ Total Number of Employees _____

Client Contacts/Client Sessions: _____

Annual Budget _____ Prior Period Budget _____

Employee Classification:

<u>Professional</u>	<u>Number of Full Time</u>	<u>Number of Part Time</u>	<u>Annual Payroll</u>
Counselor or social worker not degreed, not licensed, LPN's	_____	_____	_____
Dietitian/Nutritionist	_____	_____	_____
Doctorate Degree (Psychologist)	_____	_____	_____
Nurse or Therapist	_____	_____	_____
Social Worker (MSW, MA, Licensed) Sociologist	_____	_____	_____
Teacher	_____	_____	_____
<u>Others</u> (please list below):	_____	_____	_____

Do all Physicians (contracted or employed) carry their own Professional Liability Insurance? Yes No

F. Property

Current Insurance Company: _____

Current Premium: _____ Expiration Date: _____

Have you had any property losses or theft losses in the past 3 years? Yes No

If Yes, please provide details. (Attach separate sheet if necessary and company loss runs) _____

Loc. No.	Building Limit	Contents Limit	Valuation* Building	Contents	Deductible:
1	\$ _____	\$ _____	_____	_____	<input type="checkbox"/> 500 (minimum)
2	\$ _____	\$ _____	_____	_____	<input type="checkbox"/> 1,000
3	\$ _____	\$ _____	_____	_____	<input type="checkbox"/> 2,500
4	\$ _____	\$ _____	_____	_____	<input type="checkbox"/> Other _____

*Indicate Replacement Cost-RC or Actual Cash Value-ACV. (ACV takes depreciation into consideration and is not market value.) You must carry limits equal to at least 80% of the valuation you choose. Unless otherwise requested or indicated in proposal, Building and Contents will be insured for Special Form Perils (including theft).

OPTIONAL COVERAGE: The following coverages are available:

Coverage	Limit
Business Income/ Extra Expense	\$ _____
Signs	\$ _____
Loss of Money In & Out of Premises	\$ _____

Other coverages requested - please specify: _____

Facility Physical Characteristics	Location			
	1	2	3	4
A) Construction Type Code*	_____	_____	_____	_____
B) Number of Stories	_____	_____	_____	_____
C) Year Built	_____	_____	_____	_____
D) Exposing Buildings & Distance:	Right Exposure	_____	_____	_____
	Left Exposure	_____	_____	_____
	Rear Exposure	_____	_____	_____
E) Fire Alarm (Y/N)	_____	_____	_____	_____
F) Smoke Detectors (Y/N)	_____	_____	_____	_____
G) Emergency Lighting (Y/N)	_____	_____	_____	_____
H) Number of Exits	_____	_____	_____	_____

*1-Frame(Wood Walls, Floor & Roof Support) 2-Ordinary(Masonry Walls, Wood Floor & Roof Support)
3-Non-Combustible(Masonry or Steel Walls, Floor & Roof Support)
Mortgagee: _____
Loss Payee: _____

G. Child Day Care Center Information

- If applicant operates from a Private Home, a photo must accompany this application.
- Part occupied by applicant (basement, 1st floor, 2nd floor, etc.): _____
Inside area (dimensions, sq.ft.): _____
- Construction of building (frame, brick, fire resistive, etc.): _____ No. of floor: _____
Type of heating: _____ Age: _____
- Does applicant have a play area? Yes No If Yes, supply dimensions, a list of play equipment and security measures (fencing, locked gates, etc.): _____
- Affirmative answers to the following must be described in remarks below:
 - Pools on the premises (must be fenced) Yes No
 - Handicapped or Retarded children (other than normal) supply numbers, ages, degree of retardation, care or therapy provided. Yes No
 - Employees or contracted Physicians Yes No
 - Animals, pets (describe each) Yes No
 - Gymnastic Equipment (describe each) Yes No
 - Unique or unusual teaching techniques Yes No
 - Field trips (estimate number below) Yes No
 - Nurses, Therapists, Counselors Yes No

Remarks: _____

6. Is applicant licensed as a Day Care Center? Yes No Nursery School? Yes No If neither, explain: _____

7. How long has center been in operation? _____ Number of years under current management? _____

8. Applicant is Licensed or Certified to care for _____ children ages _____ to _____
(If no license required, state maximum numbers)

Number of children under age 2 _____ from 2 to 5 _____ from 5 to 10 _____ over age 10 _____

Applicant's ratio of supervisors to children is _____ to _____.

Applicant operates _____ days a week from _____ A.M. to _____ P.M. with an average daily attendance of _____ children.

H. Adult Day Care Center Information

1. What is maximum number of clients permitted by license? _____

2. What is maximum number of clients on premises at any one time? _____

Average daily attendance: _____

3. Please describe all the activities at this facility: _____

4. Indicate type of facility: Social Medical Mental

5. Indicate type of counseling, if any provided: Social Medical Mental

6. Is this an in-home facility? Yes No If Yes, please explain: _____

7. Is there a swimming pool on the premises? Yes No If Yes, is it fenced? Yes No

8. Describe any special equipment on premises: _____

9. Are there any non-ambulatory attendees? Yes No If Yes, how many? _____

10. Are there any Alzheimer's afflicted adults? Yes No If Yes, How many? _____

11. Describe how injuries or illnesses are handled: _____

12. Is there a doctor on staff or call? Yes No If Yes, please explain: _____

13. Is there any overnight exposure? Yes No If Yes, please explain: _____

14. Is there any physical therapy exposure at this facility? Yes No

15. Is there any administering of medicine at this facility? Yes No If Yes, please explain: _____

I. Institutional Care Liability Information

1. Construction of Building is: _____ % fire resistive _____ % masonry/block _____ % frame or brick veneer

2. Date Built? _____ No. of stories: _____ Total floor area: _____

No. of exits: _____ No. of elevators: _____

3. Was building originally constructed for use as a nursing or retirement home? Yes No

4. If No, advise date and nature of conversion: _____

5. Distance to nearest fire station? _____ Paid Volunteer

6. Is building located within corporate limits? Yes No
7. Is building sprinklered? Yes No If Yes, what percentage? (supply your best estimate) _____
8. Is fire alarm sounded: Locally Central Station Is there a service contract? Yes No
9. Licensed bed capacity? _____ Present number of patients? _____ Number of non-ambulatory patients? _____
 Classify by number between Extended Hospital Care _____ Skilled Acute Care _____ Intermediate Care _____
 Residential Care Home for Aged or Group Home _____ Other (describe) See following definitions: _____

EXTENDED HOSPITAL CARE
 nursing home facilities physically attached to a hospital or beds allocated within a hospital or nursing home care.

SKILLED ACUTE CARE- Professional nursing care 24 hours by licensed nurses. A registered nurse provides care during the day shift. LPN coverage is required during other shifts. Skilled nursing care including some or all of the following: medication administration, injections, in medication administration, tube feeding, catheterizations, or other procedures ordered by physicians.

INTERMEDIATE CARE
 Nursing care during the day shift, 7 days per week, by either registered or licensed practical nurse. No complex nursing (IV's, Tube Feeding, etc.) Assistance with activities of daily living (i.e. walking, bathing, dressing, eating) Some assistance.

RESIDENTIAL CARE HOME FOR THE AGED OR GROUP HOME-
 Residents are provided protective environments and are responsible for their own care. Group Homes are for trainable retarded persons. Residents of Home for the Aged must be ambulatory.

10. CLASSIFY NUMBER AND TYPE OF ALL PATIENTS *Classify each Patient only once by major Affliction*
- | | | | |
|-----------------------|-------------------------------------|------------------------|------------------------------|
| Surgical _____ | Drug Detox _____ | Head Trauma _____ | Battered/Abused _____ |
| Ex-Mental _____ | Drug Rehab. _____ | On Respiration _____ | Foster Care _____ |
| Aged or Senile _____ | Mentally Retarded _____ (severe) | On ventilators _____ | Orphanage _____ |
| Alcoholic Detox _____ | Mentally Retarded _____ (mild) | Dialysis _____ | Unwed Mothers _____ |
| Alcoholic Rehab _____ | Mentally Retarded _____ (trainable) | Anorexia/bulimia _____ | Other (please explain) _____ |

What is average age of patients? _____ No. of patients over age 65? _____
 between 50 and 65 _____ under age 50* _____
 Any non-ambulatory patients above first floor? Yes No If Yes, number of patients _____
 *Identify separately the afflictions of each patient under age 50 (use separate sheet if necessary): _____

11. CLASSIFY NUMBER OF EMPLOYEES BY SHIFT - With regard to this facility

	1st Shift	2nd Shift	3rd Shift		1st Shift	2nd Shift	3rd Shift
Physicians, Interns, Residents	_____	_____	_____	Respiratory Therapists	_____	_____	_____
Graduate Nurses - RN	_____	_____	_____	Occupational Therapists	_____	_____	_____
Practical Nurses - LPN	_____	_____	_____	X-ray Technicians	_____	_____	_____
Nurses' Aides	_____	_____	_____	Volunteers	_____	_____	_____
Student Nurses	_____	_____	_____	Lab Technicians	_____	_____	_____
Physical Therapists	_____	_____	_____	Special Technicians	_____	_____	_____
Inhalation Therapists	_____	_____	_____	Other (describe)	_____	_____	_____

12. Number of employed and contracted Physicians _____ Interns _____ Residents _____ Dentists _____
13. Does applicant require them to provide proof of insurance? Yes No If Yes, describe _____
14. Is facility approved for Medicare? Yes No If Yes, number of beds _____
15. Is facility approved for Medicaid? Yes No If Yes, number of beds _____

FRAUD STATEMENT: 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.

APPLICANT'S WARRANTY STATEMENT. I have read this application, and I declare that to the best of my knowledge and belief all of the foregoing statements are true and accurate, and that these statements are offered as an inducement to the Company to issue the policy for which I am applying. I agree that this application will be made a part of the policy, should the Company evidence its acceptance of this application by issuance of a policy.

Applicant's Signature _____ Date _____

Broker's Signature _____ Date _____

Address _____

THE STATE OF NEW YORK REQUIRES THAT WE HAVE THE NAME AND ADDRESS OF YOUR (INSURED'S) AUTHORIZED AGENT OR BROKER.

NAME OF AUTHORIZED AGENT OR BROKER _____

ADDRESS _____

MAIL COMPLETED
APPLICATION THROUGH
LOCAL AGENT OR
BROKER TO: