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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

JEWISH FEDERATION APPLICATION

Applicant Name:_____
Mailing Address:_____ City:_____ State:_____ ZIP:_____
Total Staff (including office, janitorial, maintenance, etc.): Full Time:_____ Part Time:_____
SIC #:_____ FEIN #:_____
Website Address:_____ Annual Revenue: $_____
Number of years this facility has been: In Operation:_____ Under current management:_____
Risk Management Contact:_____ Number:_____ Email:_____

SUBMISSION REQUIREMENTS

- ACORD applications, including Crime & Umbrella
- Statement of Values
- Photographs of the Applicant's location(s)
- Loss runs for current year and three (3) prior years
- Brochure, newsletter and website information

SECTION I – GENERAL APPLICATION INFORMATION

1. Please provide a narrative of the Applicant's operations:

2. Any mergers or operations under another name within the past five (5) years? ☐ Yes ☐ No
   Are any mergers planned / anticipated for the coming year? ☐ Yes ☐ No
   If yes to either, explain:_____
3. Annual operating budget: $_____ Annual Payroll: $_____
   Primary funding: ☐ Federal ☐ State ☐ County ☐ Other:_____
4. Does the Applicant operate any locations not included in this application? ☐ Yes ☐ No
   If yes, explain:_____
5. Attach copy of current state or other governmental license(s).
   If none, explain:_____
6. Has the Applicant's license ever been suspended, revoked, or placed under conditional status? ☐ Yes ☐ No
   If yes, explain:_____
7. Have there been any claims that allege negligence or failure to comply with any regulatory / licensing guidelines? ☐ Yes ☐ No
8. Indicate whether the Applicant's employees or independent contractors provide the following services for the Applicant's clients:
   ☐ Landscaping ☐ Re-paving / Re-surfacing ☐ Other:_____
   ☐ Janitorial/Maintenance ☐ Snow removal
9. Does the Applicant lease, sub-lease, or rent to others? ☐ Yes ☐ No
   If yes, does the Applicant obtain certificates of insurance? ☐ Yes ☐ No
10. Does the Applicant sell goods or services to members of the public (not including clients)? ☐ Yes ☐ No
    Products:_____ Annual Receipts: $_____
    Services:_____ Annual Receipts: $_____
11. Has the Applicant discontinued any programs in the past five (5) years? ☐ Yes ☐ No
    If yes, explain:_____
12. Does the Applicant participate in / or supervise any sports activities for the Applicant's clients? ☐ Yes ☐ No
    If yes, explain:_____
13. Does the Applicant have field trips? ☐ Yes ☐ No
    If yes, number per year:_____ Are any overnight? ☐ Yes ☐ No
    What is the maximum distance traveled?_____ Are release forms obtained? ☐ Yes ☐ No
    What are the controls that are in place?_____
    Describe each trip:

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SECTION II - PREMISES / LIFE SAFETY

1. If the building the Applicant occupies was built prior to 1971; has it been inspected for lead paint? ☐ Yes ☐ No
   If no, what is the plan for abatement?
   _____
2. Does the Applicant have any plans for renovations or new construction? ☐ Yes ☐ No
   If yes, explain:_____
3. Are any non-ambulatory patients above the first floor? ☐ Yes ☐ No
4. Does the Applicant have the following in place:
   Fire alarms? ☐ Yes ☐ No Central Station? ☐ Yes ☐ No
   Security alarm? ☐ Yes ☐ No Central station? ☐ Yes ☐ No
   Smoke detectors? ☐ Yes ☐ No Are smoke detectors: ☐ Hard wired ☐ Battery operated
5. Number of fire extinguishers on premises:_____ How often and by whom are they serviced?_____
6. How many means of egress are there?_____ Are all exits clearly marked & illuminated? ☐ Yes ☐ No
7. Are all exit doors equipped with panic hardware? ☐ Yes ☐ No
8. Is there a fire escape? ☐ Yes ☐ No
   If yes, describe:_____
9. Does the Applicant have a written emergency evacuation plan? ☐ Yes ☐ No
   If yes, are the emergency evacuation procedures and floor plan posted? ☐ Yes ☐ No
   Has the Applicant established a central meeting point outside the building? ☐ Yes ☐ No
   Does the emergency plan include notification to the fire department? ☐ Yes ☐ No
   How often are drills held?_____
10. Does the Applicant have emergency lighting or backup generators in the event of a power failure? ☐ Yes ☐ No
11. Does the Applicant have a formal maintenance housekeeping program in place? ☐ Yes ☐ No
12. Is the hot water heater set to a temperature of 120 degrees? ☐ Yes ☐ No
13. Has the Applicant's facility been inspected by an insurance company or independent inspection firm? ☐ Yes ☐ No
    If yes, by whom?_____
    List any deficiencies and corrective actions in the past three (3) years:
    _____
14. Does the property have aluminum wiring? ☐ Yes ☐ No
    If yes, has it been retrofitted with one of the PHLY approved connectors by a licensed Electrician? ☐ Yes ☐ No
    (indicate with one): COPALUM? ☐ Yes ☐ No AlumiConn? ☐ Yes ☐ No
    Date updated:_____
    Please supply retrofit documentation or statement from installing contractor.

SECTION III - MANAGEMENT PRACTICES

1. Does the Applicant have sign in / sign out procedures for:
   Staff ☐ Yes ☐ No
   Clients / Residents ☐ Yes ☐ No
   Visitors / Public ☐ Yes ☐ No
2. Type of security provided for the protection of the Applicant's clients / residents?
   ☐ Guards ☐ Video Cameras ☐ Other:_____
3. What measures are taken to monitor client activities?_____
4. What precautions does the Applicant take to prevent non-staff members from accessing unauthorized areas of the property?
   _____
5. Does the Applicant have incident reporting procedures and / for committee reviews? ☐ Yes ☐ No
6. Is the Applicant's staff made aware of reporting procedures? ☐ Yes ☐ No
7. Does the Applicant have a plan for medical emergencies? ☐ Yes ☐ No
8. Is there always someone trained in CPR and first aid on the premises? ☐ Yes ☐ No
9. Does the Applicant have Automatic External Defibrillator(s)? ☐ Yes ☐ No
10. What percentage of total staff including volunteers are trained to use the AED?_____%
11. Have the police and / or fire departments been called to any of the Applicant's premises in the past three (3) years? ☐ Yes ☐ No
    If yes, explain:_____
12. Does the Applicant have a written and enforced no smoking policy? ☐ Yes ☐ No
13. Are "no smoking" signs posted in all areas not designated for smoking? ☐ Yes ☐ No
14. Does the Applicant use padded rooms? ☐ Yes ☐ No
15. How often are the rooms sanitized?_____
16. Does the Applicant use electric shock treatment? ☐ Yes ☐ No

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SECTION IV - PROFESSIONAL LIABILITY

1. **Hiring Practices:**
2. Does the Applicant require staff (paid and Volunteer) to complete an employment application? ☐ Yes ☐ No
   If no, explain: _____
3. Does the Applicant conduct a personal interview for each prospective staff member? ☐ Yes ☐ No
4. Does the Applicant verify education references? ☐ Yes ☐ No
5. Does the Applicant verify employment related references? ☐ Yes ☐ No
6. Does the Applicant verify licenses and other credentials? ☐ Yes ☐ No
7. Does the Applicant obtain criminal background checks on all staff members before hiring them? ☐ Yes ☐ No
8. Does the Applicant require drug tests on all staff members, including drivers? ☐ Yes ☐ No
   If yes: ☐ Before hiring ☐ After hiring ☐ Random
9. What are the Applicant's procedures for evaluating all these reports?

   _____
10. What actions does the Applicant take if any report is considered unfavorable?

    _____
11. Does the Applicant share written job descriptions with all staff members? ☐ Yes ☐ No
12. Name of executive director / manager: _____
    Number of years experience in this field: _____ Number of years at this facility: _____
    Specialized training or education: _____
13. Are any staff members under 18 years of age? ☐ Yes ☐ No
    If yes, list their position(s) and how they are supervised:

    _____
14. What is the staff turnover rate for the last 12 months? _____
15. Does the Applicant provide workers compensation for :
    ☐ All staff members ☐ Workshop Employees ☐ Contractors ☐ Consultants
16. Is the staff required to report to the administrator all incidences that may result in a claim? ☐ Yes ☐ No
    If yes, is a written record kept? ☐ Yes ☐ No Are they reviewed? ☐ Yes ☐ No
17. Are clients referred to specialists when appropriate? ☐ Yes ☐ No
18. Are files maintained to protect confidentiality of clients? ☐ Yes ☐ No
19. Does the Applicant do any consulting work? ☐ Yes ☐ No
    If yes, explain: _____
20. Does the Applicant's current insurance program provide professional liability coverage? ☐ Yes ☐ No
    If yes: ☐ Occurrence or ☐ Claims-made - Retroactive Date: _____ Limit of Liability: $ _____
    Carrier: _____ Effective date: _____
21. Do psychiatrists prescribe experimental drugs / treatment? ☐ Yes ☐ No
22. Has anyone ever had a patient who committed suicide? ☐ Yes ☐ No
23. Does the Applicant's psychiatrist get a second opinion when uncertain of the diagnosis? ☐ Yes ☐ No
24. **Physicians and Psychiatrists:**

Name	Dr.		Dr.		Dr.	
Specialty:						
Board certified or eligible:						
Years in practice:						
License Number:						
Hours per week for insured:						
Employed or Contracted?						
Does each Individual carry his / her own malpractice insurance?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
If yes, does coverage include acts while working for center?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
If yes, does coverage include contingent coverage for center?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Any claims past five (5) years?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

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SECTION IV - PROFESSIONAL LIABILITY (CONTINUED)

25. Annual Staffing – Employees, Independent Contractors and Volunteers
Total number of: Full time employees: _____ Part Time Employees: _____ Volunteers: _____

Staffing	# of Employees		# of Contracted		Total Annual Volunteer Hours Worked
	FT	PT	FT	PT	
Psychologist					
Medical Director (Admin Only)					
Nurse Practitioner					
Physician Assistant					
Pharmacist					
Paramedic EMT					
Psychiatrist					
Physician-Hospice					
Pediatrician					
Physician-No Surgery					
Dentist					
Optometrists/Ophthalmologist					
Licensed Social Worker					
Sociologist					
Registered Nurse (RN)					
Licensed Practical Nurse (LPN)					
Physical Therapist					
Optician					
Orthotics & Prosthetics (O&P) Certified Practitioner					
Counselor (Guidance, Vocational)					
Social Worker					
Occupational Therapist					
Speech Therapist					
Clergy / Rabbi / Pastor					
O&P Certified Technician					
Teacher					
Nutritionist / Dietician					
Residential Manager					
Home Health Aide					
Day Care Worker					
O&P Certified Fitter					
O&P Certified Assistant					
Adoptions					
Foster Care					
*Other (describe):_____					
*Other (describe):_____					

F/T = Full Time – over 20 hours per week/ P/T = Part Time – up to 20 hours per week.
* Please describe "other" staff positions not listed in the above chart in the provided area.

26. **If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.**

27. **If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects to the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least $1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.**

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28. Consultant / Independent Contractors:
Are there written agreements with independent contractors? ☐Yes ☐No
Are certificates of malpractice/professional liability insurance obtained and maintained for all contracted service providers (independent contractors)? ☐Yes ☐No
Please indicate the limits of liability: $_____

29. Has the Applicant's operations / facilities ever been accredited / certified by CARF, JCAHO, ECFA, COA, ACHC or similar organization created to serve the Human/Behavioral/Healthcare Services Industry? ☐Yes ☐No
If yes:
Name of Accrediting Organization: _____
Date of Accreditation / Certification: _____
Term of Accreditation / Certification: _____

SECTION V - ABUSE AND MOLESTATION

1. Does the Applicant's current insurance program include Abuse and Molestation Coverage? ☐Yes ☐No
If yes, ☐Occurrence or ☐Claims Made – Retro Date:_____ Limits of Liability: $_____
Carrier:_____ Effective Date:_____
2. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? ☐Yes ☐No
3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if the Applicant has incident of abuse? ☐Yes ☐No
4. Are there written complaint procedures and are they displayed prominently? ☐Yes ☐No
If yes, explain:

5. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises? ☐Yes ☐No
6. Are formal written procedures in place for hiring? ☐Yes ☐No
7. Do volunteers work directly with clients? ☐Yes ☐No
8. Is there formal staff training on child/sexual abuse, including how to recognize the signs? ☐Yes ☐No
How often is staff trained?_____
9. What procedures are in place to make sure no relationship occurs between staff and clients?

10. Are there procedures prohibiting closed door one-on-one meetings / counseling? ☐Yes ☐No
11. Is there more than one person responsible for the welfare of any single patient? ☐Yes ☐No
12. Have any incidents resulted in an allegation of sexual abuse? ☐Yes ☐No
Was the case settled? ☐Yes ☐No Was the case taken to trial? ☐Yes ☐No
Amount paid for damages to the victim: $_____
13. Does the Applicant run criminal background checks on employees? ☐Yes ☐No
14. Does the Applicant run criminal background checks on volunteers? ☐Yes ☐No

SECTION VI - CLAIMS MADE ☐ N/A

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

Policy Effective Date:_____
Line of Business:_____

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant? ☐Yes ☐No
If yes, please provide details:

2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? ☐Yes ☐No
If yes, please provide details:

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SECTION VII - AUTOMOBILE ☐ N/A

1. Are all vehicles listed on the ACORD application titled to the applicant? ☐ Yes ☐ No
   If no, explain:_____
2. Where does the Applicant keep own vehicles?
   ☐ Garage ☐ Driveway ☐ Parking lot ☐ Other:_____
3. Are keys locked and secured away from non-drivers when not in use? ☐ Yes ☐ No
4. Are vehicles with eight or more seating capacity equipped with an audible backup warning device? ☐ Yes ☐ No
5. Does the Applicant provide pickup or delivery of donated merchandise? ☐ Yes ☐ No
6. Does the Applicant provide transportation for:
   ☐ Staff ☐ Clients / Residents ☐ Visitors / Public ☐ Meals
   If yes for clients / residents, is more than one staff member required in the vehicle? ☐ Yes ☐ No
   If yes for meals, what precautions does the Applicant take to prevent food spoilage?
   _____
7. Does the Applicant transport clients / residents for other private or government agencies? ☐ Yes ☐ No
   If yes, explain:_____
   If yes, for a fee? ☐ Yes ☐ No
8. Does the Applicant provide transportation for field trips? ☐ Yes ☐ No
   If the Applicant does not provide the transportation, how is it provided?
   _____
   If vehicles are hired for field trips, are they hired with a driver? ☐ Yes ☐ No
9. If children are transported, is there a monitor to ensure their safety during transportation? ☐ Yes ☐ No
10. Do the Applicant's employees/volunteers transport children in their own vehicles? ☐ Yes ☐ No
    If yes, how often?_____
11. Are vehicles checked after passengers disembark to make sure no one is left behind? ☐ Yes ☐ No
12. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? ☐ Yes ☐ No
13. Does the Applicant require seat belts to be worn by all occupants? ☐ Yes ☐ No
14. Does the Applicant have a vehicle maintenance program in place? ☐ Yes ☐ No
15. Does the Applicant's organization utilize GPS fleet telematics devices? ☐ Yes ☐ No
    If yes, please check off the fleet telematics being utilized:
    ☐ Plug in ☐ Hard wired ☐ Mobile Phone ☐ Other:_____
16. What percentage of the Applicant's fleet is provided with these fleet telematics devices?_____%

SECTION VIII – DRIVERS ☐ N/A

1. Does the Applicant obtain a written authorization to release driver information from all of staff upon hiring? ☐ Yes ☐ No
   Does the Applicant obtain MVRs on all drivers? ☐ Yes ☐ No If yes, how often?_____
2. What are the Applicant's procedures for dealing with driver accidents or violations?_____
3. Are all drivers at least 21 years of age? ☐ Yes ☐ No
4. How many drivers (employees and volunteers) aged 21 to 25 transport clients in agency vehicles?_____
5. Do any drivers have a Commercial Driver's License? ☐ Yes ☐ No
6. Explain the Applicant's driver safety program:_____
7. Is training provided for new employees/volunteers prior to their transporting clients? ☐ Yes ☐ No
   If yes, explain:_____
8. Does anyone besides employees or volunteers drive the Applicant's vehicles? ☐ Yes ☐ No
   If yes, explain:_____
9. Does the Applicant allow personal use of the Applicant's vehicles? ☐ Yes ☐ No
   If yes, by whom and for what reasons?
   _____

SECTION IX - HIRED AND NON-OWNED VEHICLES ☐ N/A

1. Does the Applicant hire vehicles? ☐ Yes ☐ No
   If yes, what types of vehicles does the Applicant hire?_____
   Does the Applicant obtain certificates of insurance? ☐ Yes ☐ No
   What minimum limits does the Applicant require? $_____
2. How many drive personal vehicles for business use regularly? F/T:_____ P/T:_____ Vol:_____
   How many drive personal vehicles for business use occasionally? F/T:_____ P/T:_____ Vol:_____
   Does the Applicant obtain proof of insurance for employees/volunteers who use their own autos? ☐ Yes ☐ No
   Does the Applicant update these records at least yearly? ☐ Yes ☐ No
   What minimum limits does the Applicant require? $_____

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SECTION X

ADOPTION PLACEMENT AGENCY ☐N/A **FOSTER CARE PLACEMENT AGENCY** ☐N/A

1. Is the Applicant licensed in all states in which it operates? ☐Yes ☐No
   List states:_____
2. Are the adoption services: ☐Opened ☐Closed
   Total number of anticipated adoptions in the next 12 months:_____
   Is the adoption agency Hague approved? ☐Yes ☐No
   Does Applicant do Embryo Adoptions? ☐Yes ☐No
3. International adoptions: ☐Yes ☐No
   Total number of anticipated international adoptions in the next 12 months:_____
4. Total number of foster families at any one time:_____
5. Anticipated number of foster children over the next 12 months:
   Ages: Less than 1 year:_____ 1-5:_____ 6-10:_____ Over 10:_____
   Please identify the number of special needs foster care placement included in this number:_____
6. Average number of foster children who are placed multiple times:_____
7. Total number of training hours for each foster family prior to placement of first child:_____
8. Total annual number of training hours for each family:_____
9. Are caseworkers supervised? ☐Yes ☐No
   Are decisions made by a team? ☐Yes ☐No
10. Are home studies conducted? ☐Yes ☐No
    What are staff member's credentials?

_____

11. Is there a written procedure in place to analyze potential applicants? ☐Yes ☐No
12. Are criminal records checked prior to approval of a home? ☐Yes ☐No
13. Does the Applicant verify homeowners insurance or renters insurance? ☐Yes ☐No
14. Does the Applicant have written procedures for dealing with a report of abuse? ☐Yes ☐No
15. Are children given thorough medical examinations, with prior conditions noted, before they are placed? ☐Yes ☐No
16. Is counseling provided to the birthparents after placement? ☐Yes ☐No
17. Are children given to adoptive parents upon release from hospital? ☐Yes ☐No
18. Are they placed in a foster home until the time lapses for the mother to change her mind? ☐Yes ☐No
19. Do the adoptive/foster parents receive special counseling after placement? ☐Yes ☐No
20. Does the Applicant do follow-up visits after placement has been made? ☐Yes ☐No
    Are these visits unannounced? ☐Yes ☐No
    How often do they occur?_____
    When do these visits stop?_____
21. What are the rights of the child's biological grandparents?_____
22. Total stipend amount paid to foster parents annually:_____
    Foster Care annual stipend: $_____
23. Total annual receipts for: Domestic Adoptions: $_____ International Adoption: $_____
24. Please advise additional screening criteria of Foster Parents to satisfy eligibility for special needs placements, and indicate if follow up visits are more frequent if the placement involves a special needs child.

_____

25. Are any of the Applicant's Foster Care Services contracted to third party organizations, or, does the Applicant conduct any foster care operations as a contractor on behalf of a separate organization? ☐Yes ☐No
    If yes, please complete Section XII, Question 8 in its entirety for your Foster Care Services

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SECTION XI – FOSTER CARE SERVICES PROVIDER

1. Number of active Foster Homes / Foster Familes in service:_____
2. Total number of Foster Children served annually:_____
3. Number of years the Applicant has operated Foster Care program:_____
4. Foster Care Services (check all that apply)
   - ☐ Foster Home/Foster Family Screening (Studies)
   - ☐ Foster Home/Foster Family Certification
   - ☐ Foster Home/Foster Family Licensing
   - ☐ Foster Care Assessments
   - ☐ Case Management
   - ☐ In Home support services
   - ☐ Foster Parent counseling
   - ☐ Emergency Shelter
5. Please list any affiliated Foster Child Placement Agencies:

---

a. Do Agencies listed above carry primary liability insurance? ☐ Yes ☐ No
b. Do Agencies listed above offer claim settlements under a state fund? ☐ Yes ☐ No

6. Does the Applicant follow state regulations mandating Foster Care Procedures? ☐ Yes ☐ No
7. Are audit procedures in place to ensure home visits are being conducted? ☐ Yes ☐ No
   Are there standards of practice with respect to documentation and is there a method for immediate reporting / escalation for emergency incidents? ☐ Yes ☐ No
8. Are any of the Applicant's Foster Care Services contracted to a third party organization, or, does the Applicant conduct any foster care operations as a contractor on behalf of a separate organization? ☐ Yes ☐ No
   If yes, please answer the below:
   a. Does the Applicant confirm that General Liability coverage, Professional Liability coverage and Sexual Abuse or Molestation Liability coverage are carried at equal limits by all contracting parties? ☐ Yes ☐ No
   b. Does the Applicant require independent contractors to add them as additional insured onto their policy? ☐ Yes ☐ No
   c. Is the Applicant required by written contract to hold harmless, indemnity or add any third party organization as additional insured? ☐ Yes ☐ No
   d. Do all of the Applicant's contracting or subcontracting agreements include hold harmless & indemnification clauses in their favor or, at a minimum, mutually exclusive? ☐ Yes ☐ No
   e. Does the applicant execute a hold harmless agreement with the individual foster families that they serve? ☐ Yes ☐ No
   f. Please list any third party entities with whom the Applicant has contracted for foster care services and identify what amount of the Applicant's services are provided on a contractual basis:

Contracted Organization	Service	% of Operations
		%
		%
		%
		%
		%
		%
	Total	%

Note: Contracts include those in which the Applicant is either the contractor or subcontractor.
% of operations represents foster care operations, totals should equal 100%
All contract agreements and provisions are subject to receipt and review.

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SECTION XII – FOOD PREPARATION FACILITIES ☐ N/A

1. The food preparation equipment is: ☐Electric ☐Gas ☐Propane ☐Other: _____
2. The food preparation equipment is in:
   ☐One common area ☐Each floor ☐Individual rooms ☐Other: _____
   Total number of cooking areas: _____
3. Who has access to the cooking area: ☐Staff ☐Clients/Residents ☐Visitors/Public
4. For who is the food prepared? ☐Staff ☐Clients/Residents ☐Visitors/Public
   If for the public, explain:

   _____
5. Is the food properly covered, stored and served? ☐Yes ☐No
6. Do the Applicant's staff members supervise the cooking area? ☐Yes ☐No
7. Are there fire extinguishers in the cooking area? ☐Yes ☐No
8. The cooking equipment is: ☐Residential ☐Commercial
9. Cooking equipment is equipped with: ☐Nothing ☐Hoods ☐Ducts ☐Exhaust Fans
   ☐Automatic fuel shut off controls ☐Automatic fire suppression system ☐Other: _____
10. How often is the cooking equipment cleaned:
    Cleaned by: ☐Applicant ☐Cleaning contractor
11. Do the hoods have removable filters? ☐Yes ☐No

SECTION XIII - SHELTERED WORKSHOP ☐ N/A

1. Describe work/product being performed: _____
2. Does the Applicant perform industrial sub-contracted work: e.g., packaging, assembling, and actual manufacturing of a finished product? ☐Yes ☐No
3. What company label goes on the product? _____
4. Who is the ultimate user of the product? _____
5. Is there renovation or processing of used materials? ☐Yes ☐No
   If yes, describe materials: _____
6. Are flammables stored in proper receptacles? ☐Yes ☐No
7. What controls are in place for painting, stripping, finishing, welding, metalworking, woodworking, etc.?

   _____
8. Are hazardous operations separated; e.g., paint spray booths, welding booths, dipping tanks, sawing/sanding areas? ☐Yes ☐No
   If yes, describe how:

   _____
9. When was the last time the workshop was inspected by OSHA? _____
   Were any deficiencies noted? ☐Yes ☐No
   If yes, explain:

   _____
10. Is there proper ventilation for the work being performed? ☐Yes ☐No
    Describe frequency and type of waste disposal:

    _____
11. Quality control program in place? ☐Yes ☐No
12. Do counselors make follow up visits to clients placed in outside employment? ☐Yes ☐No

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SECTION XIV - RESIDENTIAL FACILITIES ☐ N/A

RESIDENTS	# BEDS	RESIDENTS	# BEDS	RESIDENTS	# BEDS
Acute Skilled Care		Inpatients Crisis Center		Respite Care	
Aged		Low Income Housing		Transitional Housing	
Group Home		Shelter-Abuse Victims		Youth Homes	
Hospice		Shelter-Homeless		Other: (specify)_____	
Independent Living		Shelter-Other:_____		Other: (specify)_____	

1. Annual number of clients by age group:
   Less than 18:_____ 18-35:_____ 36-65:_____ Over 65:_____
2. Annual number of clients by disability: Emotional/Behavior:_____ Drug/Alcohol:_____
   Developmental Disability:_____ Intellectual Disability:_____
3. Specify number of Male:_____ Female:_____ Co-Ed:_____
4. Are residents separated? ☐Yes ☐No
   How are they separated?_____
5. Average length of stay:_____
6. Number of non-ambulatory patients:_____ What floor are they located on?_____
7. Total number of rooms:_____ Number of bedrooms:_____
8. What was the date of the last inspection by a licensing agency?_____
   Were there any violations or deficiencies noted? ☐Yes ☐No
   If yes, explain:_____
9. Does a physician screen clients prior to admission? ☐Yes ☐No
10. Does the Applicant require a signed release form for the release of records to other individuals or institutions? ☐Yes ☐No
11. Are residents primarily responsible for their own basic personal care including bathing, dressing, eating, and restroom aide? ☐Yes ☐No
12. Is the staff trained in non-violent crisis intervention? ☐Yes ☐No
    If yes, which protocol?_____
13. What type of method does the Applicant use for de-escalation?_____
    Is it approved? ☐Yes ☐No
14. What is the Applicant's physical restraint policy?_____
15. What is the ratio of resident to staff: Day:_____ Night:_____
16. What procedures are in place for clients who are permitted to leave the premises without supervision?

    _____
17. How many visits per month are made by a caseworker to a resident?_____
18. How does the Applicant provide for the resident's privacy and individual security?_____
19. How often are rooms inspected?_____
    Who inspects the rooms?_____
    Does the Applicant have written procedures? ☐Yes ☐No
    Does the Applicant keep a checklist? ☐Yes ☐No
20. How often are bed checks done? ☐Random ☐Scheduled
21. How is staff monitored?_____
22. Are there security cameras monitoring operations? ☐Yes ☐No
23. Are residents' doors ever locked from the outside? ☐Yes ☐No
24. Are residents allowed to cook their own meals? ☐Yes ☐No
    If yes, in ☐Private or ☐Common cooking areas
25. Does the Applicant own or operate a Nursing Home or Assisted Living Facility? ☐Yes ☐No
    If yes, explain:_____

SECTION XV - MEDICAL FACILITIES ☐ N/A

1. Does the Applicant own or operate a Medical Clinic? ☐Yes ☐No
   If yes, are the facilities for: ☐ Staff ☐Clients/Residents ☐General Public
2. What are the facility hours?_____
3. Does the Applicant provide more than immediate care/first aid? ☐Yes ☐No
   If yes, explain:_____
4. By job title, who staffs the facilities?_____
5. Does the Applicant keep only over the counter drugs on the premises? ☐Yes ☐No

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If no, explain:_____

6. Which staff members dispense the medications?_____
7. Are the medications and equipment kept in a locked facility? ☐Yes ☐No
   If no, where are they kept?_____
   Which staff members have access?_____
8. Does the Applicant have policies and procedures in place for prescribing/administering medication? ☐Yes ☐No
   If yes, explain:_____
9. What medical equipment does the Applicant have?_____
10. Does the Applicant maintain a log of all those who receive care? ☐Yes ☐No
11. Does the Applicant maintain medical history and care records for each individual? ☐Yes ☐No

SECTION XVI - IN-HOME SUPPORT SERVICES ☐ N/A

1. Services:

☐Bathing	☐Eating	☐Medication management	☐Running errands
☐Blood testing	☐Housework	☐Nursing care	☐Social work
☐Changing catheters	☐Infusion therapy	☐Nutrition counseling	☐Speech therapy
☐Dressing	☐Laundry	☐Repositioning	☐Other:_____
☐Driving clients to & from appointments	☐Meal preparation	☐Restroom aid	☐Other:_____

2. How long has the program been in place?_____
3. How many employees provide in-home services?_____ Volunteers:_____
4. Number of non-ambulatory clients:_____
5. Payroll for the last 12 months: $_____
6. Does the Applicant sell and/or rent medical equipment? ☐Yes ☐No
   Receipts sales: $_____ Receipts rentals: $_____
7. Is all staff informed of AIDS/HIV patients? ☐Yes ☐No
8. Does the Applicant have written procedures in place to prevent theft from the clients' homes? ☐Yes ☐No
9. Explain types of training the Applicant's staff receives:_____
10. Are medications administered? ☐Yes ☐No
    Only as prescribed by a physician? ☐Yes ☐No
    What types of medication are administered?_____
11. Are visits documented? ☐Yes ☐No
    How is staff monitored?_____

SECTION XVII - SUBSTANCE ABUSE PROGRAMS ☐ N/A

1. Is treatment: ☐Individual or ☐Group
   Number of individual sessions annually:_____ Number of group sessions annually:_____
2. Does the Applicant provide a methadone maintenance program? ☐Yes ☐No
   If yes, where is the methadone stored?_____
   Number of methadone-only clients annually:_____ Number of clients with take home privileges:_____
   Describe measures to guard against the diversion of methadone by employees and/or clients:
   _____
3. Does the Applicant operate a detoxification unit? ☐Yes ☐No
   If yes, ☐Medical ☐Other:_____
   If Medical, does the Applicant accept clients with a history of delirium tremens (DTs) or seizures? ☐Yes ☐No
   If clients are experiencing DTs or seizures, does the Applicant:
   ☐Treat them or ☐Refer them to a hospital?
4. Does the Applicant operate drug/alcohol rehabilitation? ☐Yes ☐No
   If yes, are these for adults only? ☐Yes ☐No
   Are facilities single sex? ☐Yes ☐No Co-ed? ☐Yes ☐No

SECTION XVIII - OUTPATIENT FACILITIES ☐ N/A

TYPE OF SERVICE	# VISITS	TYPE OF SERVICE	# VISITS

1. Annual number of clients by age group: Less than18:____ 18-35:____ 36-65:_____ Over 65: _____
2. Annual number of clients by disability: Emotional/Behavior:_____ Drug/Alcohol:_____
   Developmental Disability:_____ Intellectual Disability:_____

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3. Explain screening procedures for clients:

4. Does the Applicant operate a clinic? ☐ Yes ☐ No
   If yes, is it open to the public? ☐ Yes ☐ No
5. Does the Applicant offer group therapy? ☐ Yes ☐ No
   If yes, average size of group:_____ How often does the group meet per week?_____
   Explain nature of problems treated/discussed:

6. Does the Applicant operate a crisis hotline? ☐ Yes ☐ No
   If yes, annual number of calls received:_____
   What types of calls? ☐ Suicide ☐ Drug/Alcohol ☐ Child/Spousal Abuse ☐ Other:_____
   What are the hours of operation for the hotline?_____
   Is training provided? ☐ Yes ☐ No Do volunteers answer calls? ☐ Yes ☐ No
7. Does the Applicant provide adult day care? ☐ Yes ☐ No
   If yes, indicate number of clients per day:_____
8. Does the Applicant provide any programs for sexual offenders? ☐ Yes ☐ No
   If yes, number of visits and describe typical offenses:_____
9. Does the Applicant provide any programs for juvenile delinquents? ☐ Yes ☐ No
   If yes, number of clients and describe typical offenses:_____
10. Does the Applicant provide any services for ex-offenders or incarcerated individuals? ☐ Yes ☐ No
    If yes, number of clients and describe typical offenses:_____
11. Does the Applicant provide respite care programs? ☐ Yes ☐ No
    If yes, maximum amount of consecutive days:_____
    Does the Applicant: ☐ Take all ages or ☐ Does the Applicant specialize?
    Explain:

    Can parents / caretakers meet and interview the people who will be providing care? ☐ Yes ☐ No
    How far ahead of time do parents/caretakers need to call to arrange for services?_____
    Does the Applicant maintain records of services? ☐ Yes ☐ No
    Does the Applicant provide follow-up to families that have been served? ☐ Yes ☐ No
    Does the Applicant take care of other family members (e.g., siblings)? ☐ Yes ☐ No
    What is the cost of services? $_____ How is payment arranged?_____
12. Does the Applicant make telephone referrals? ☐ Yes ☐ No
    If yes, annual number of calls:_____
13. Are children's services available for the children of the Applicant's counseling patients? ☐ Yes ☐ No
    Average number of children:_____ Number of staff:_____ Hours of operation:_____
14. Does the Applicant operate a meal delivery service? ☐ Yes ☐ No
    If yes, number of meals annually:_____
    Does the Applicant charge a fee? ☐ Yes ☐ No
    If yes, total revenue: $_____

SECTION XIX - THERAPEUTIC HORSEBACK RIDING ☐ N/A

Attach a copy of medical, rider's registration, and liability release forms.

1. Are liability waivers signed by all parents/guardians? ☐ Yes ☐ No
2. Does the Applicant follow North American Riding for the Handicapped Association standards? ☐ Yes ☐ No
3. Does the Applicant or the Applicant's instructors have regional or national riding certificates? ☐ Yes ☐ No
4. Does the Applicant fasten a child to any part of the saddle? ☐ Yes ☐ No
5. Are safety helmets mandatory? ☐ Yes ☐ No
6. Does the Applicant provide transportation to and from the facility? ☐ Yes ☐ No
7. Total annual lessons:_____ Average size of group:_____
8. What is the experience of the staff?

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SECTION XX - POOL ☐ N/A

1. Is there a trained lifeguard on duty? ☐Yes ☐No
   If yes, how many?_____ During what hours?_____
2. The pool area includes: ☐Hot tub ☐Kiddie pool ☐Trampoline ☐Whirlpool
   ☐Jacuzzi ☐Spa ☐Water slide ☐Other:_____
3. Who uses the area? ☐Visitors/Public ☐Staff ☐Clients/Residents
4. Is the pool completely fenced with a self-locking gate? ☐Yes ☐No If yes, what is the height?_____
5. Pool Location: ☐Indoors ☐Outdoors
6. Is there a diving board? ☐Yes ☐No If yes, what is the height?_____
7. Are depths clearly marked? ☐Yes ☐No
   Is walking surface around the pool non-skid and in good condition? ☐Yes ☐No
8. Is life saving equipment readily accessible? ☐Yes ☐No
9. Is the staff trained in water safety? ☐Yes ☐No
10. Are all areas of the pool, including the bottom, visible at all times? ☐Yes ☐No
11. Are "swim at your own risk" signs posted with pool rules? ☐Yes ☐No
    Do the posted rules meet state and local regulations? ☐Yes ☐No
12. Are swimming lessons given? ☐Yes ☐No If yes, by whom?_____
13. Is there any swim team participation? ☐Yes ☐No
    If yes, explain:_____
14. Is the storage of pool chemicals secured? ☐Yes ☐No
15. How often is the pool cleaned?_____
16. Does the Applicant have specific guidelines regarding closing the pool due to water contamination? ☐Yes ☐No
17. Number of Pools:_____
    Are all swimming pools and spas compliant with Virginia Graeme Baker Pool and Spa Safety Act? ☐Yes ☐No
    If no, provide time table and action plan:
    _____

SECTION XXI- LAKES / PONDS *(Enclose copy of lake/pond rules.)* ☐ N/A

1. Maximum depth?_____
2. Is the lake fenced? ☐Yes ☐No Are hazards within the lake roped off? ☐Yes ☐No
3. Does the public have access to the lake area? ☐Yes ☐No
4. Are there boat docks? ☐Yes ☐No If yes, where?_____
5. If swimming is allowed, is there a lifeguard on duty? ☐Yes ☐No If yes, during what hours?_____
6. Lake use (check all that apply):
   ☐Canoes ☐Ice fishing ☐Jet skis ☐Power boats (max horse power ☐Row boats ☐Swimming
   ☐Fishing ☐Ice skating ☐Paddle boats and length allowed):_____ ☐Sail boats ☐Water skiing
7. Is there watercraft rental? ☐Yes ☐No
   If yes, what types?_____ Annual receipts: $_____
8. Are there separate and designated usage areas? ☐Yes ☐No
9. Is the lake/pond susceptible to freezing? ☐Yes ☐No

SECTION XXII - PLAYGROUND ☐ N/A

1. Is the playground area supervised during all open hours? ☐Yes ☐No
2. Who uses the areas? ☐Staff ☐Clients/Residents ☐Visitors/Public
3. Is the play area fenced? ☐Yes ☐No If yes, describe fencing:_____
4. Describe all playground equipment including the maximum height of the equipment:_____
5. Describe surface under playground equipment:_____
   Depth of surface:_____

SECTION XXIII - FITNESS AREA ☐ N/A

1. Is the fitness area supervised during all open hours? ☐Yes ☐No
2. Is it open at any time when the Applicant's facility is closed? ☐Yes ☐No
   If yes, when and why?_____
3. Who uses the area? ☐Staff ☐Clients/Residents ☐Visitors/Public
4. Describe all fitness equipment and facilities (both indoor and outdoor):

   _____
5. How often and by whom is the equipment and area inspected?_____
   Does the Applicant keep logs of users? ☐Yes ☐No
6. Does the Applicant require hold harmless/waivers to be signed by all users? ☐Yes ☐No

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SECTION XXIV - CAMPS ☐ N/A

1. Is written permission/waiver of liability obtained from every child's parent or guardian? ☐ Yes ☐ No
2. Does the camp provide overnight services? ☐ Yes ☐ No
   If yes, what is the average length of stay?_____
3. Total number of days in operation annually:_____ Number of children at each camp:_____
4. Number of staff members at each camp:_____
5. What are the qualifications of staff working with children?_____
6. Are sleeping quarter's co-ed? ☐ Yes ☐ No Are restrooms/showers co-ed? ☐ Yes ☐ No
7. If well water, how often is it tested?_____
8. Indicate and describe if any of the following exposures exists in the camp operations:
   ☐ Archery ☐ Guns ☐ Jet skis ☐ Motor boats ☐ Obstacle course ☐ Water skiing
   ☐ Diving boards ☐ Horses ☐ Lakes ☐ Pools ☐ Rock climbing ☐ Other:_____

SECTION XXV – ADULT DAY CARE

Type of Day Care:		# of Total Clients Served	% of Services
Type I:	Adult day social care provides social care and social activities such as meals, recreation and some basic health-related services such as having a nurse on staff to check pressure (Light exposures).		%
Type II:	Adult day health care offers more intensive health, therapeutic, and social services for individuals with moderate to severe medical and cognitive problems including an incidental exposure (up to 25%) of clients with Alzheimer's. Activities within this category also include social activities for clients that require more intense health, therapeutic and medical care. (Moderate to heavy exposures)		%
Type III:	Alzheimer's specific adult day care provides social and health services to persons with Alzheimer's or related dementia. The predominant exposure in this category are clients with this diagnosis or organizations that have an Alzheimer's or related dementia exposure greater than an incidental as outlined within the Type II description.		%

For Type II and III, please outline the types of medical services provided:

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SECTION XXVI - PLANNED EVENTS / FUND RAISERS** ☐ N/A

*** If Insured has more than five (5) events planned for the upcoming policy period, photocopy this page and add additional events.*

QUESTIONS	EVENT #1	EVENT #2	EVENT #3	EVENT #4	EVENT #5
Describe the type of event*					
* Insert letter for type of event: A = Wine tasting B = Golf outing C = Other sporting event (specify) D = Picnic E = Banquet F = House tour G = Bingo H = Walkathon I = Fashion show J = Concert (specify) K = Other (specify)					
Date(s) the event is held.					
Daily hours of operation.					
Total anticipated revenue.	$	$	$	$	$
Held at Applicant's premises? If not, specify where it is held.					
Number of participants.					
Number of staff members.					
Are certificates of insurance obtained from everyone providing products / services?					
If there will be drinking at the event, how does the Applicant control the amount allowed?					
Who provides / serves the alcohol? Liquor license required?					
Are the bartenders hired by the Applicant or by the place where the event is held?					
Do the bartenders know TIPS?					
If applicable, list all sporting activities to be a part of this event.					
What safeguards are in place to prevent spectator injury?					
Do participants sign a waiver?					
Do participants show proof of personal health insurance?					

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WINTER WEATHER FREEZE PROTECTION

The Winter Weather Freeze Section is mandatory on all risks that have a prior winter freeze loss greater than $25,000 or 10% of the building TIV in the past 5 years OR a location in states commonly experiencing freezing temperatures.

These states include but are not limited to: AL, AR, AZ, CO, CT, DE, DC, GA, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY

1. Can the Applicant reliably confirm that all areas of the Applicant's building with fire sprinkler piping and/ or domestic water lines can be maintained at 45° F or higher? ☐Yes ☐No ☐N/A
   This includes exterior accessed sprinkler riser rooms, as well as attics, crawl spaces, and stairwells if they have water lines in them.
   a. If not, select all freeze protection measures currently in place:
      - ☐Temperature monitoring and remote heating control system (Wi-Fi temperature controls)
      - ☐PHLYSense
      - ☐Other water detection/ notification/ alarm system
      - ☐Backup electrical generator, ensuring building heat at all times
      - ☐Insulation around water pipes in cold areas*
      - ☐Heat tracing for water pipes in cold areas*
      - ☐Antifreeze fire sprinkler system in cold areas*
      - ☐Space heaters or heated forced air in attics, crawl spaces, stairwells with fire sprinklers
      - ☐Other:

      _____

   * Cold areas are defined as portions of a building that cannot be maintained at all times reliably at or above 45° F.
2. Fire Protection and Testing
   a. Is the building provided with an Automatic Fire Sprinkler System (AS)? ☐Yes ☐No ☐N/A
      i. If yes, what type of sprinkler system is installed? ☐Wet-Pipe ☐Dry-Pipe ☐Both
      ii. If yes, approximately what percentage (%) of the building is sprinklered? _____%
      iii. If yes, has the system been tested & inspection by qualified sprinkler contractor within past 12 months & includes a formal winterization review? ☐Yes ☐No ☐N/A
      iv. If yes, are the alarms tied to a 24 hour UL listed monitoring company? ☐Yes ☐No ☐N/A
3. Emergency Water Response (domestic and AS water lines)
   a. Are water shutoff valves (domestic and AS water lines) marked and readily accessible? ☐Yes ☐No ☐N/A
   b. Are water shutoff valves exercised (closed and reopened) at least annually? ☐Yes ☐No ☐N/A
   c. Is the staff qualified to respond and shut off the water main during normal business hours and off hours? ☐Yes ☐No ☐N/A
4. Automatic Water Shutoff Devices
   a. For domestic water lines, is there a water flow detection, notification and automatic shutoff? ☐Yes ☐No ☐N/A
5. Unused/ Vacant Spaces
   a. Does Applicant have a formal process to turn off and drain domestic water lines for these spaces? ☐Yes ☐No ☐N/A
6. Seasonal Occupancies ONLY:
   a. Is there a full-time caretaker/ maintenance personnel on the premise? ☐Yes ☐No ☐N/A
      If yes, select required duties of the caretaker:
      - ☐Regular walkthroughs of the building
        i. How often each day?_____
      - ☐Trained in the location(s) of water shut off valve(s)
      - ☐Inspects taps and leaves them dripping in freeze weather events
      - ☐Shuts off or drains pipes during freezing temperatures
      - ☐Monitors building temperatures ensuring heat is maintained at required levels
      - ☐Responds to power outages
        i. List of required procedures

      _____

   b. If no caretaker is present, has the building been properly winterized including water turned off, pipes drained, heat maintained, proper pipe insulation, etc.? ☐Yes ☐No ☐N/A

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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

Underwritten by:
Philadelphia Indemnity Insurance Company

CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

Name of Applicant:_____
Address of Applicant:_____
City:_____ State:_____ Zip:_____
Website: www:_____
Nature of Operations:_____

---

1. Annual sales or revenue: $_____

2. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? ☐ Yes ☐ No
   If yes, please indicate the types of Personally Identifiable Information held (check all that apply):
   - ☐ a. Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers
   - ☐ b. Non-public Medical or Healthcare Data, including Protected Health Information (PHI)
   - ☐ c. Credit or Debit Card Information

3. a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? ☐ Yes ☐ No
   b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? ☐ Yes ☐ No
   c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? ☐ Yes ☐ No
   d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? ☐ Yes ☐ No

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FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that they/ them are an authorized representative of the Applicant and declares to the best of their knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

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 THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). **(NOT APPLICABLE IN AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NY, OH, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, LA, MD, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON (IN ALABAMA, MAYBE SUJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF).

APPLICABLE IN CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDLENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

APPLICABLE IN COLORADO: 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.

APPLICABLE IN DISTRICT OF COLUMBIA: 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.

APPLICABLE IN FLORIDA 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.

APPLICABLE IN KANSAS: AN ACT COMMITTED BY 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, 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 MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS 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.

APPLICABLE IN MAINE: 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.

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APPLICABLE IN NEW JERSEY: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN NEW MEXICO: 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.

APPLICABLE IN OHIO: 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.

APPLICABLE IN OKLAHOMA: 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.

APPLICABLE IN PENNSYLVANIA: 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.

APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON: 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.

APPLICABLE IN VERMONT: 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.

APPLICABLE IN NEW YORK: 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. THIS APPLIES TO AUTO INSURANCE.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, BOARD CHAIR, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

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