PHILADELPHIA INSURANCE COMPANIES

A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

ADULT DAY CARE PROGRAM SUPPLEMENTAL

Named Insured:
Location Address:
E-mail: Web Address:
Risk Management Contact: Risk Management's Phone:
Risk Management Email:

REQUIREMENTS FOR SUBMISSION

- Completed and signed/dated PHLY Adult Day Care Supplemental Application
- Completed ACORD Application
- Copy of current Adult Day Care license(s)
- Brochures, pamphlets and/or other advertising materials
- Currently valued insurance company loss runs for the current policy period plus three prior years

SECTION I – GENERAL APPLICATION INFORMATION

1. This adult day care center is located in which type of building?
   Commercial Church School
   Other (describe): Private Home (**NOT Eligible**)
2. The neighborhood is primarily:
   Commercial / Industry Residential Urban / City Country / Farming
3. Hours of operation:
4. Any overnight stays? Yes No
5. Number of successful years in business under the same management:
6. Indicate if a file containing the following information is maintained on each client:
   a. Are there records for each client indicating unusual conditions the client has? Yes No
   b. Are signed releases for emergency medical treatment/dispensing of medication obtained from guardians? Yes No
   c. Are written instructions from client's physicians for dispensing of client's medication? Yes No
7. Is food properly covered, stored and served in accordance with applicable government requirements? Yes No

Licensing:

1. Is the adult day care center licensed? Yes No
   If yes: License #: Expiration date of license: License Capacity:
2. If licensing is NOT state required, why is it exempt?
3. Has a license to operate ever been denied, suspended or revoked? Yes No
   If yes, attach a separate full explanation.
4. Does Applicant provide transportation? Yes No
5. Has the Applicant ever received any citations or warnings issued by any state or governmental entity? Yes No

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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:

SECTION II – MANAGEMENT PRACTICES

1. Does Applicant have sign in / out procedures for:
   Staff? Yes No Clients/Residents? Yes No Visitors/Public? Yes No
2. Type of security provided for the protection of your clients / residents?
   Guards Video Cameras Other:
3. What measures are taken to monitor client activities?
4. Describe the procedures currently in place, which prevents the clients from wondering off or outside the premises?
5. What precautions do you take to prevent non-staff members from accessing unauthorized areas of the property?
6. Do you have incident reporting procedures and / or committee reviews? Yes No
7. Do you 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. Do you have Automatic External Defibrillator(s)? Yes No
10. Are staff members trained to use it? Yes No
11. Do you have a written and enforced no smoking policy? Yes No
12. Are "no smoking" signs posted in all areas not designated from smoking? Yes No

SECTION III – PROFESSIONAL LIABILITY

1. Does the Applicant require their staff (paid & volunteer) to complete an employment application? Yes No
   If no, please explain:
2. Does the Applicant conduct a personal interview for each prospective staff member? Yes No
3. Does the Applicant verify employment related references? Yes No
4. Does the Applicant verify licenses and other credentials? Yes No
5. What action does the Applicant take if any report is considered unfavorable?
6. Does the Applicant share written job descriptions with all staff members? Yes No
7. Name of executive director / manager:
   Number of years experience in this field: Number of years at this facility:
   Specialized training or education:
8. What is the staff turnover rate for the last twelve (12) months?
9. Does the Applicant provide workers compensation for:
   All staff members Workshop Employees Contractors Consultants
10. Is the staff required to report to the administrator all incidences that may result in a claim? Yes No
    If yes, is a written report kept? Yes No Are they reviewed? Yes No
11. Are clients referred to specialists when appropriate? Yes No
12. Are files maintained to protect confidentiality of clients? Yes No
13. Does the Applicant do any consulting work? Yes No
    If yes, please explain:

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14. Does the Applicant's current insurance program provide professional liability coverage? Yes No
If yes: Occurrence Claims Made – Retroactive date: Limits: $
Carrier: Effective dates:

15. **Physicians and Psychiatrists**

Name:	**Dr.**		**Dr.**		**Dr.**	
Specialty:						
Board certified or eligible:						
Years in practice:						
License Number:						
Hours per week for Applicant:						
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

16. 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.

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17. **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.**
18. **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.**
19. **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: $
20. Based on the **maximum number** of clients enrolled on your **busiest** day, enter the numbers of staff and clients in each of the following categories:

TYPE OF ADULT DAY CARE	# OF CARE PROVIDERS		# OF CLIENTS
	MALE	FEMALE	
TYPE I			
TYPE II			
TYPE III			

(The ratios of staff-to-client must be at least the state required ratio)

21. Are any **staff** less than 18 years old? Yes No
    (Indicate specific duties for each on a separate document.)
22. Does the Applicant use any volunteers? Yes No
    (Indicate specific duties for each on a separate document.)
23. Is a minimum of one staff member certified in First Aid present at all times? Yes No
24. Is a minimum of one staff member certified in CPR present at all times? Yes No

SECTION IV – HIRING / SCREENING

1. Are employees screened to rule out drug, alcohol and sexual abuse? Yes No
2. Check all methods used in hiring all employees or independent contractors:
   Drug Testing? Criminal Background Checks – Federal Criminal Background Checks – State
   Reference Checks Personal Interview Sexual Abuse Registry Validate Driver's License
   Validate Work History Validate Education Verify Current Certification / Professional License
   Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours)
3. How are references checked: Written Verbal Both
   If verbal only, please explain:
4. Are all of the above methods done prior to binding? Yes No
   If no, please explain:

SECTION V – SEXUAL ABUSE N/A

1. Does the Applicant's current insurance program include Abuse and Molestation Coverage? Yes No
   If yes, Occurrence or Claims Made – Retro Date: Limit 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
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

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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 – PREMISES / LIFE SAFETY

1. If the building you occupy 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 property have aluminum wiring? Yes No
   If yes, has it been retrofitted with one of the PHLY approved connectors by a licensed Electrician?
   (indicate which one): COPALUM? Yes No AlumiConn? Yes No
   Date updated: Please supply retrofit documentation or statement from installing contractor.
3. Have asbestos material been:
   determined **not** to be present removed or protected to prevent flaking?
4. Do you have any plans for renovations or new construction? Yes No
5. Does the Applicant's center exit directly to the outside? Yes No
   To ground level? Yes No
6. Are there any non-ambulatory clients? Yes No
   If yes, how many? Any located above the first floor? Yes No
7. Please indicate which of the following fire suppression devised are currently in use and in effect:
   Automatic Sprinkler System Central Station Fire Alarm System Smoke Detectors
   Manual Pull Fire Alarms Fire Extinguishers Other:
8. How many means of egress are there?
   Are all exits clearly marked & illuminated? Yes No
9. Are all exit doors equipped with panic hardware? Yes No
10. Is there a fire escape? Yes No
    If yes, please describe:
11. Do you have a written emergency evacuation plan? Yes No
    If yes, are the emergency evacuations procedures and floor plan posted? Yes No
    Have you 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?
12. Do you have emergency lighting or backup generators in the event of a power failure? Yes No
13. Do you have a formal maintenance housekeeping program in place? Yes No
14. Do you own or rent a parking facility? Yes No
    If yes, are they well lit? Yes No
15. Is the hot water heater set to a temperature of 120 degrees? Yes No
    Do you have an equipment maintenance program in place? Yes No
16. Has your facility been inspected by an insurance company or independent inspection firm? Yes No
    If yes, by whom?
    On a separate sheet, please list any deficiencies and corrective actions in the past three (3) years:
17. Does the Applicant comply with board of health regulations and with building codes? Yes No
18. Are medical facilities, such as a first aid or nurse's station located on the premise? Yes No
19. Please indicate the dates of the latest updates regarding the following common hazards:
    Electrical/Wiring: Plumbing: Heating:
    Type of Heating: Type of Roof: Age of Roof:

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SECTION VII – 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.

N/A (Please proceed to signature section)

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:

SECTION VIII - AUTOMOBILE

Owned Automobiles

1. Are all vehicles listed on the ACORD application titled to the Applicant? Yes No
   If no, please explain:
2. Where does the Applicant keep their 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 audile backup warning device? Yes No
5. 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 do you take to prevent food spoilage?
6. Does the Applicant transport clients / residents for other human services agencies? Yes No
   If yes, please explain:
7. Does the Applicant provide transportation for field trips? Yes No
   If the Applicant does not provide transportation, how is it provided?

   If vehicles are hired for field trips, are they hired with a driver? Yes No
8. Does the Applicant's employees / volunteers transport clients in their own vehicles? Yes No
   If yes, how often?
9. Are vehicles checked after passengers disembark to make sure no one is left behind? Yes No
10. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? Yes No
11. Does the Applicant require seat belts to be worn by all occupants? Yes No
12. Does the Applicant have a vehicle maintenance program in place? Yes No
13. 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:
14. What percentage of the Applicant's fleet is provided with these fleet telematics devices? %

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Hired and Non-Owned N/A

1. Does the Applicant hire vehicles? Yes No
   If yes, what type of vehicles does the Applicant hire?

   Does the Applicant obtain Certificates of Insurance? Yes No
   What minimum limits does the Applicant require? $
2. Does the Applicant hire from a transportation company? Yes No
   If yes, with drivers? Yes No
3. Total number of hired vehicles: Annual cost of hire: $
4. 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 Applicant require? $

Drivers N/A

1. Does the Applicant obtain a written authorization to release driver information from all of the Applicants 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 twenty-one (21) years of age? Yes No
4. How many drivers (employees and volunteers) aged twenty-one (21) to twenty-five (25) transport clients in agency vehicles?
5. Do any drivers have a Commercial Driver's License (CDL)? 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, please explain:
8. Does anyone besides employees or volunteers drive Applicant's vehicles? Yes No
   If yes, please explain:
9. Does the Applicant allow personal use of the Applicant's agency vehicles? Yes No
   If yes, by whom and for what reasons?

SECTION IX – SWIMMING POOLS N/A

1. Is there a training lifeguard on duty? Yes No
   If yes, how many? During what hours?
2. The pool area includes:
   Jacuzzi Whirlpool Hot Tub Spa Kiddie Pool Water Slide Trampoline
3. Is the pool completely fences with a self-locking gate? Yes No
   If yes, what is the height?
4. Pool location: Indoor Outdoor
5. Is there a diving board? Yes No
   If yes, what is the height?
6. Are depths clearly marked? Yes No
7. Is life saving equipment readily accessible? Yes No
8. Is walking surface around the pool non-skid and in good condition? 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. Is the storage of pool chemicals secured? Yes No

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13. How often is the pool cleaned?
14. Do you have specific guidelines regarding closing the pool due to water contamination? Yes No
15. Are all swimming pools and spas complaint with the Virginia Graeme Baker Pool and Spa safety act? Yes No
    If no, provide time table and action plan:

SECTION X – FIELDTRIPS / OFF PREMISES TRAVEL N/A

1. Are field trips taken (or do you anticipate field trips during the next 12 months)? Yes No
   If yes, answer the following:
2. Describe the field trips:
3. Does the Applicant travel off premises for other events such as fundraising events? Yes No
4. Describe those trips:

SECTION XI – SPECIAL EVENTS N/A

1. Are any pets or animals kept on premises? Yes No
   Describe animals, caging, and type of interaction:
2. Are special classes provided? (Exercise, Dance, etc.) Yes No
   If yes, please explain:
3. Are special classes taught by an independent contractor on your premises? Yes No
4. Does Applicant request / maintain Certificates of Insurance from all sub-contractors? Yes No
5. Does the Applicant have any operations other than Adult Day Care? Yes No
   If yes, please explain:

SECTION XII – KITCHEN EXPOSURE N/A

1. Is cooking permitted on the premises? Yes No
2. Is the actual cooking of food prepared and cooked by the staff? Yes No
3. Are there fire extinguishers in the cooking area available? Yes No
4. The cooking equipment is: Residential Commercial
5. Cooking equipment is equipped with:
   Nothing Hoods Ducts Exhaust Fans
   Automatic Fire Suppression System Automatic Fuel shut off control
6. How often is the cooking equipment cleaned?
   Is the cleaning equipment: Cleaned by you Cleaning Contractor

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WINTER WEATHER FREEZE-UP PROTECTION

This section must be completed by all risks that have a location in one of the following states: AR, CT, DC, DE, GA, IL, IN, KY, ME, MD, MA, MI, MO, NH, NY, NJ, NC, OH, PA, RI, SC, TN, TX, VT, VA, WV, WI

1. Fire Protection and Testing
   a. Is the building provided with an Automatic Fire Sprinkler System (AS)? Yes No N/A
      i. If yes, approximately what percentage (%) of the building is sprinklered? %
      ii. If yes, what type of sprinkler system is installed? Wet-Pipe Dry-Pipe Both
      iii. If yes, when possible, is the sprinkler piping primarily run within conditioned areas designed to ensure the temperature remains above the 45°F minimum temperature? Yes No N/A
         1. If no, please describe freeze prevention measures (e.g. temperature monitoring, heat trace, full insulation on piping or roof):
      iv. If yes, is the testing & inspection by qualified sprinkler contractor completed within past 12 months & includes a formal winterization review? Yes No N/A
      v. If yes, are the alarms tied to a 24 hour UL listed monitoring company? Yes No N/A
2. 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
3. Automatic Water Shutoff Devices
   a. For domestic water lines, is there a water flow detection, notification and automatic shutoff? Yes No N/A
4. 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
5. Unheated Areas (attics, crawl spaces, exterior wall joists)
   a. Are all domestic water lines located in areas heated to at least 45°F? Yes No N/A
      i. If no, please describe freeze prevention measures (e.g. temperature monitoring, heat trace, full insulation):
6. General Comments:

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FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her 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 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). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, 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 OR CONFINEMENT IN 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 FLORIDA AND OKLAHOMA: 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 (IN FL, A PERSON 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 MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICABLE IN MAINE, 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, 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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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:

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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

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her 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 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). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, 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 OR CONFINEMENT IN 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 FLORIDA AND OKLAHOMA: 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 (IN FL, A PERSON 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 MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICABLE IN MAINE, 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, 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)