

HUMAN SERVICES RENEWAL SUPPLEMENT

Name Insured:

Annual Revenue: \$

Total Staff (including office, janitorial, maintenance, etc): Full Time: Part Time:

 1. Have there been any new programs added or any changes in operations? Yes No
 If yes, please describe fully:

 2. Is the Applicant's organization more than 25% owned by a private equity fund structure? Yes No
 If yes, provide name of private equity firm:

3. Risk Management Contact: Phone Number: Email:

SECTION I - PROFESSIONAL LIABILITY

PROFESSIONAL STAFFING:

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					

Staffing	# of Employees		# of Contracted		Total Annual Volunteer Hours Worked
	FT	PT	FT	PT	
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.

- 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.**

If the Physician, Psychiatrist, Dentist or Optician currently has medical professional coverage with the company, the Applicant will not need to submit a newly completed medical professional application. Please confirm names of medical professionals that are currently insured with company.

Name	Specialty

- 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.**
- Are there written agreements with independent contractors? Yes No
- Are certificates of malpractice / liability insurance obtained and maintained for all contracted services providers (independent contractors)? Yes No
- Please indicate limits of liability: \$

SECTION II - POOL / SPA

N/A

- 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 III- PLANNED EVENTS / FUND RAISERS**

N/A

** If Insured has more than ten (10) events planned for upcoming policy period, copy 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 type) 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.					

QUESTIONS (continued)	EVENT #1	EVENT #2	EVENT #3	EVENT #4	EVENT #5
What safeguards are in place to prevent spectator injury?					
Do participants sign a waiver?					
Do participants show proof of personal health insurance?					
QUESTIONS	EVENT #6	EVENT #7	EVENT #8	EVENT #9	EVENT #10
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 type) 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?					
SECTION IV - ADOPTION N/A / FOSTER CARE N/A					

- Total number of anticipated adoptions in the next 12 months:
- International adoptions? Yes No
Total number of anticipated international adoptions in the next 12 months:
- Total number of foster families at any one time:
- Anticipated number of foster children over the next 12 months?
Ages: Less than 1 year: 1 – 5: 6 – 10: Over 10:
- What are the total annual receipts for Adoption? \$
- What are the total annual stipends for Foster Care? \$

SECTION V - UMBRELLA

If umbrella covers Employer's Liability:

Each Accident: \$ Policy Limit: \$ Each Employee: \$
Carrier: Term: to

SECTION VI - AUTO

- 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:
- What percentage of the Applicant's fleet is provided with these fleet telematics devices? %

SECTION VII – 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:

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: | | | |

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.

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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.

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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)



CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

Name of Applicant:
Address of Applicant:
City:
Website: www:
Nature of Operations:

State: Zip:

-
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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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)