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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

MENTAL HEALTH RENEWAL APPLICATION

Applicant's Name:_____
Number of years under present management:_____
Annual Operating budget: $_____ Payroll: $_____
Risk Management Contact:_____ Risk Management's Phone:_____
Risk Management Email:_____

1. Are any mergers planned/anticipated for the coming year? ☐Yes ☐No
   If yes, please explain.

   _____
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. Does the Applicant provide integrated behavioral health and primary medical care services? ☐Yes ☐No
   If yes, please describe your integrated care model.

   _____
4. Are any new programs or services planned/anticipated for the coming year? ☐Yes ☐No
   If yes, please explain.

   _____
5. What is the staff turnover rate for the last 12 months?_____
6. Total number of clients:_____
7. What is the percentage of clients receiving addiction treatment services?_____%
8. Please provide the percentage of the age of clients served:

Client	Percentage	Client	Percentage
Children (1 – 12)	%	Adults	%
Teenagers	%	Geriatric (over 65)	%

9. 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)					

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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					
*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.

10. Does the Applicant provide any foster care or adoption services? ☐Yes ☐No
If yes: # of foster care children placed:_____ # of adoptions:_____

11. **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

12 **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.**

13. What is the staff-to-client ratio for each program?

Program	Staff	Clients	Ratio

13. Is the Applicant aware of any circumstances which may result in any claim or suit, including request for medical records? ☐Yes ☐No
Please describe all claims.

14. Are all areas of buildings with wet pipe sprinkler systems (hidden or unhidden) maintained at a minimum temperature of 40° F, and / or provided with proper insulation or heat tracing to prevent pipe freeze-ups? ☐Yes ☐No

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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?_____%

MENTAL HEALTH FACILITIES PROVIDING ADDICTION TREATMENT SERVICES

ASAM Criteria Levels of Care

Level	Service Provided	%	Level	Service Provided	%
0.50	Early Intervention		III.3	Clinically Managed Population Special High Intensity Residential Services	
I	Outpatient Services		III.5	Clinically Managed High Intensity Residential	
II.I0	Intensive Outpatient		III.7	Medically Monitored Intensive Inpatient	
II.50	Partial Hospitalization		IV	Medically Managed Intensive Inpatient	
III.10	Clinically Managed Low Intensity Residential		OTS	Opioid Treatment Services	

Client	Percentage
Male	%
Female	%
Previously participated in detox programs	%
Violent Offender	%

1. What percentage of operations does this treatment represent?_____%
2. If a methadone treatment program is provided:
   a. Is the Applicant's program maintenance only, or do you offer methadone detox?_____
   b. Number of methadone-only clients annually:_____
   c. Number of clients with take home privileges:_____
   d. Describe measures to guard against the diversion of the methadone by employees and/or clients:

_____

3. Does the Applicant provide other Medication Assisted Treatment (MAT)? ☐Yes ☐No
If yes, please provide the following:
   a. What percentage of operations does this treatment represent?_____%
   b. Name of the medications administered:

_____

   c. Total number of clients treated annually:_____
4. Does the Applicant maintain all medications in a locked area? ☐Yes ☐No
5. Do the Applicant's intake procedures include a physical examination? ☐Yes ☐No
6. Do the Applicant's intake procedures include blood tests? ☐Yes ☐No
   a. If yes, are the blood tests used for any purpose outside of drug testing? ☐Yes ☐No
   b. If yes, please describe any other uses and possible disclosures from blood tests:

_____

7. Do the Applicant's services include a detoxification unit? ☐ Yes ☐ No
   If yes, is it Social or Medical? ☐ Social ☐ Medical
   If "Medical", do you accept clients with a history of delirium tremens (DTs) or seizures? ☐ Yes ☐ No
   If clients are experiencing DTs or seizures, do you treat them or refer them to a hospital?
   ☐ Treat them ☐ Refer them to a hospital
   If "Medical", please provide breakdown in staffing during the first 72 hours
   # of Physicians: _____ # of Nurse Practitioners: _____ # of RNs: _____ # of LPNs: _____
8. Does the Applicant perform any "rapid detox" or any detox under general anesthesia? ☐ Yes ☐ No
9. Does the Applicant's program include providing services for Correctional Facilities? ☐ Yes ☐ No
   a. If yes, what percent of your overall operation: _____%

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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

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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).

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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)

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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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NAME (PLEASE PRINT/TYPE)

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

SIGNATURE

DATE

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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)

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