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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 SUPPLEMENTAL APPLICATION

Pages 1 – 9 and the Fraud Statement must be completed by all Applicants
If you would like a quote for D & O and EPLI, please complete pages 11 & 12

Applicant's name:_____
Website address:_____
☐ Non Profit ☐ For Profit
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:_____
Number of years: In operation?_____ Under present management?_____
Accreditations: ☐ JCAHO ☐ CARF ☐ COA ☐ Other:_____
Risk Management Contact:_____ Phone Number:_____ Email:_____

REQUIREMENTS FOR SUBMISSION

- Completed ACORD Application(s)
- Statement of Values
- Brochures and / or website information
- Currently valued insurance company loss runs for the current policy period plus three (3) prior years
- Copy of all current licenses

SECTION I – GENERAL APPLICANT INFORMATION

1. Applicant's annual operating budget: $_____ Applicant's annual payroll: $_____
2. Total number of clients:_____ Total number of methadone-only clients:_____
3. Have there been any mergers or operations under another name within the past 5 years? ☐ Yes ☐ No
4. Are any mergers or changes in operation anticipated? ☐ Yes ☐ No
   If Applicant answered yes to either question #3 or #4 above, please explain on a separate sheet.
5. Has the Applicant's license ever been suspended, revoked, or placed under conditional status? ☐ Yes ☐ No
6. a. Have there been any claims that allege negligence or failure to comply with regulatory standards? ☐ Yes ☐ No
   b. Have there been any substantiated incidents? ☐ Yes ☐ No
   If yes, please send a copy of the most current federal, state or agency complaint investigation report.
7. Has the Applicant discontinued any programs in the past five years? ☐ Yes ☐ No
   If yes, please explain:

_____

8. Facility director information:_____
   Name:_____ Education level:_____
   Number of years' experience:_____ Number of years at this facility:_____

SECTION II – AGENCY SERVICES AND PROGRAMS

1. Does the Applicant provide inpatient services? ☐ Yes ☐ No
   If yes, please complete SECTION VII – RESIDENTIAL FACILITY
2. Does the Applicant provide integrated behavioral health and primary medical care services? ☐ Yes ☐ No
   If yes, please describe your program model:

_____

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3. Does the Applicant provide any of the following behavioral health services? (check all that apply)

☐ Adoption*	____%	☐ Ex-Offender	____%	☐ Personality disorder	____%
☐ Adult day care	____%	☐ Family therapy	____%	☐ Post traumatic stress	____%
☐ Alzheimers	____%	☐ Fire starters	____%	☐ Public clinic	____%
☐ Anxiety disorder	____%	☐ Foster care*	____%	☐ Rape counseling	____%
☐ Attention deficit	____%	☐ For profit program	____%	☐ Schizophrenia	____%
☐ Autism	____%	☐ Home based Hotline	____%	☐ School based	____%
☐ Boot Camp	____%	☐ Jail diversion	____%	☐ Sexual aggression	____%
☐ Crisis stabilization	____%	☐ Juvenile justice	____%	☐ Sheltered Workshop	____%
☐ Correctional facility	____%	☐ Learning disorders	____%	☐ Shock therapy	____%
☐ Court designated criminally insane	____%	☐ Lock Down Facility	____%	☐ Smoking cessation	____%
		☐ Manic disorder	____%	☐ State hospitals/ institutions	____%
☐ Day care	____%	☐ Medication Assisted Treatment	____%	☐ Other: _____	____%
☐ Depression	____%	☐ Methadone maintenance	____%	☐ Other: _____	____%
☐ Detoxification*	____%	☐ Mobile crisis	____%		
☐ Eating disorders	____%	☐ Pedophile treatment	____%		

* If adoption, drug and alcohol or foster care services are provided, supplemental applications must be completed.

4. What is the percentage of clients receiving addiction treatment services? _____%
5. 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: _____
6. Does the Applicant's program include involuntary treatment (other than alcohol-related traffic offenders)? ☐ Yes ☐ No
   If yes, what % of your overall operation? _____%
7. Does the Applicant provide or utilize telemedicine or telehealth services? ☐ Yes ☐ No
   If yes, please provide the following:
   a. Complete description of the services:
   _____
   b. Include the names and qualifications of all health professionals involved
      1) _____
      2) _____

SECTION III – RISK ASSESSMENT

1. Has the Applicant implemented an evidence-based program? ☐ Yes ☐ No
   If yes, please provide the name of the program(s) you have implemented:
   1._____ 2._____
2. Please provide the percentage of the age of clients served:

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

3. Does the Applicant's organization have formal risk management guidelines for Applicant's practitioners to follow? ☐ Yes ☐ No
4. Are the guidelines reviewed every two years? ☐ Yes ☐ No
5. Does the Applicant's staff receive job descriptions? ☐ Yes ☐ No
6. Is formal training provided to staff? ☐ Yes ☐ No
7. What is your de-escalation/physical restraint policy?
   _____
8. During intake, are screening practices written and clearly communicated to all practitioners to quickly identify how well the individual matches the organization's services? ☐ Yes ☐ No
9. Are written instructions and training provided to Applicant's staff that:
   a. Identify urgent need? ☐ Yes ☐ No
   b. Ensure a prompt response to emergency situations? ☐ Yes ☐ No

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c. Provide timely initiation of services? ☐Yes ☐No
d. Provide measurement and feedback to management? ☐Yes ☐No

10. Do the Applicant's intake procedures include a risk assessment that identifies specific characteristics of the individual served for potential suicide? ☐Yes ☐No
11. Have any of the Applicant's clients attempted or died of suicide? ☐Yes ☐No
If yes, please indicate:

Year	# of clients	Year	# of clients

12. Does the Applicant use a no suicide contract? ☐ Yes ☐No
13. Does the Applicant administer medications? ☐ Yes ☐No
If yes, please complete the following questions:
a. At the time the individual enters the Applicant's organization, is a complete list of medications he or she is taking created and documented? ☐ Yes ☐No
b. At the time the individual is transferred within or outside the Applicant's organization, does the current provider inform and document the receiving provider about the medication list? ☐ Yes ☐No
c. At the time an individual leaves the Applicant's organization, is a current list of medications provided and explained to the individual, family and the individual's primary care provider? ☐ Yes ☐No
14. Does the Applicant's risk management program include instructions for medical record documentation? ☐ Yes ☐No
If yes, is there a quality improvement program in place to monitor the documentation? ☐ Yes ☐No
15. Does Applicant use electric shock treatment? ☐ Yes ☐No
16. Are written agreements in place with independent contractors? ☐ Yes ☐No
17. Are certificates of liability insurance obtained and maintained for all contracted service providers /independent contractors? ☐ Yes ☐No
Please indicate the limit of liability required: $_____
18. Does the Applicant operate a medical clinic? ☐ Yes ☐No
If yes, is it open to the public? ☐ Yes ☐No
19. Does Applicant sponsor any fund raising activities? ☐ Yes ☐No
If yes, on a separate sheet please provide a list with a description of each.

SECTION IV – PROFESSIONAL LIABILITY

1. Does the Applicant's current insurance program include coverage for Professional Liability? ☐ Yes ☐No
If yes, please provide carrier information.
2. Prior carrier:

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made or Occurrence	Retroactive Date (Claims Made Only)
			$		
			$		
			$		
			$		

3. Has any company declined, canceled or refused to renew any of the Applicant's Professional Liability insurance? ☐ Yes ☐No
4. 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					
*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.

5. Does the Applicant provide any foster care or adoption services? ☐ Yes ☐ No
   If yes: # of foster care children placed: _____ # of adoptions: _____
6. **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.**
7. **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 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.**
8. Is the Applicant aware of any circumstances which may result in any claim or suit, including request for medical records? ☐ Yes ☐ No
   On a separate sheet, show all professional claims.
9. Does the Applicant's psychiatrist, employed or contracted, prescribe experimental drugs or treatment? ☐ Yes ☐ No

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SECTION V – HIRING AND SCREENING

1. Check methods used for all employees, independent contractors or volunteers:
   - ☐ Criminal Background Checks ☐ Federal ☐ State
   - ☐ Drug Testing
   - ☐ MVR
   - ☐ Personal Interview
   - ☐ Reference Checks
   - ☐ Sexual Abuse Registry
   - ☐ Validate Driver's License
   - ☐ Validate Education
   - ☐ Validate Personal Auto Insurance and Limits
   - ☐ Validate Work History
   - ☐ Verification of current certification/professional license
   - ☐ Other: _____
2. How are references checked? ☐ Written ☐ Verbal ☐ Both
3. Are all methods completed before an offer of employment is made? ☐ Yes ☐ No
4. Does the applicant have a formal volunteer program? ☐ Yes ☐ No
5. Does the Applicant verify if potential employees and individual contractors have ever had their license revoked or suspended, or disciplinary action taken against them? ☐ Yes ☐ No
6. What is the staff turnover rate? _____

SECTION VI – BUILDING INFORMATION ☐ N/A

(Please complete for each location)

1. Does the property have aluminum wiring? ☐ Yes ☐ No
   If yes, has it been retrofitted by a licensed electrician? ☐ Yes ☐ No
   Indicate which method: ☐ COPALUM crimp ☐ AlumniConn ☐ CO/ALR Devices ☐ Pigtailed
2. Sprinklers? ☐ Yes ☐ No If yes, area of coverage: _____
3. 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
4. Is cooking conducted on the premises? ☐ Yes ☐ No If yes, is equipment: ☐ Residential ☐ Commercial
   If commercial, are the installation, inspection and maintenance in accordance with the standards and requirements of NFPA 96 standards? ☐ Yes ☐ No
5. Are swimming pools located on the premises? ☐ Yes ☐ No
   If yes, are all swimming pools & spas compliant with Virginia Graeme Baker Pool & Spa Safety Act? ☐ Yes ☐ No
6. Emergency lighting? ☐ Yes ☐ No
7. Fire alarms? ☐ Yes ☐ No
8. Smoke Detectors? ☐ Yes ☐ No If yes: ☐ Battery operated ☐ Hard wired
9. Are evacuation routes posted throughout the building? ☐ Yes ☐ No
10. In the event of an evacuation, has a central meeting point outside the building been established? ☐ Yes ☐ No
11. Are exit signs illuminated? ☐ Yes ☐ No
12. Are fire drills held? ☐ Yes ☐ No
13. Are there at least two exit doors per building? ☐ Yes ☐ No
14. Are exit doors equipped with panic hardware? ☐ Yes ☐ No
15. Are handrails on all ramps and steps? ☐ Yes ☐ No
16. Is smoking permitted inside the building? ☐ Yes ☐ No
17. Have all buildings built before 1971 been inspected for lead paint? ☐ Yes ☐ No
18. Type of security provided: ☐ Guards ☐ Video Camera ☐ Other: _____

SECTION VII – RESIDENTIAL FACILITY ☐ N/A

(Please complete for each residential facility)

Facility address: _____

Licensed capacity - number of beds: _____ # of stories: _____ Year built: _____

1. Type of facility:
   - ☐ Alcohol / drug abuse
   - ☐ Assisted living
   - ☐ Boarding/rooming house
   - ☐ Developmental disabled
   - ☐ Hospice
   - ☐ Lock down facility
   - ☐ Mental health
   - ☐ Nursing home
   - ☐ State hospital/Institution
   - ☐ Supervised living
   - ☐ Transitional
2. Referral Source:
   - ☐ Case manager
   - ☐ Community agencies
   - ☐ Court ordered
   - ☐ Extended care facility
   - ☐ Hospital
   - ☐ Hotline
   - ☐ Mobile crisis unit
   - ☐ Physicians office
   - ☐ Suicide Intervention
   - ☐ Other: _____
   - ☐ Other: _____

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3. Are residents screened by a physician prior to admission? ☐ Yes ☐ No
   If no, on a separate sheet please describe the procedure that determines who is eligible for admission.
4. Resident age groups: Infant:_____% Under 18: _____% 18 – 65: _____% Over 65: _____%
   ☐ Male ☐ Female ☐ Co-ed
   How are residents separated?_____
5. Number of beds: _____ Average occupancy:_____ Average length of stay?_____
6. Number of non-ambulatory clients:_____
7. Are resident's rooms located on the ground floor? ☐ Yes ☐ No
8. Are formal sign-in and sign-out procedures in place? ☐ Yes ☐ No
9. On a separate sheet, please describe discharge policy.
10. What is the staff-to-client ratio for each program?

Program	Staff	Clients

11. What is the staff turnover for the last 18 months?_____
12. Has the Applicant developed written procedures for a standardized "handoff" process to ensure accurate communication of essential elements of care between shift changes? ☐ Yes ☐ No
13. What is your de-escalation/physical restraint policy?
    _____
14. Bed check procedures:
    a. Time intervals:_____
    b. Qualifications of staff performing:_____
    c. Documentation procedures:_____
    d. Video surveillance: ☐ Yes ☐ No
15. Water heater temperature setting:_____ Are anti-scald devices installed? ☐ Yes ☐ No

SECTION VIII – ABUSE AND MOLESTATION

1. 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 offense, before an offer of employment is made? ☐ Yes ☐ No
2. Does the Applicant have a plan of supervision that monitors staff in day-to-day relationships with clients both on and off premises? ☐ Yes ☐ No
3. Has the Applicant's organization ever had an incident which resulted in an allegation of sexual abuse? ☐ Yes ☐ No
   a. Was a claim made against the organization? ☐ Yes ☐ No
   b. Was a claim made against any employee? ☐ Yes ☐ No
      If yes, is that individual still employed with the Applicant's organization? ☐ Yes ☐ No
   c. Was the case settled? ☐ Yes ☐ No
   d. What changes were made to prevent reoccurrence?_____
   On a separate sheet, please describe all claims.
4. Does the Applicant have written abuse and molestation procedures and are they clearly communicated to all employees, independent contractors and volunteers? ☐ Yes ☐ No
5. Does the Applicant's current insurance program include coverage for Abuse and Molestation? ☐ Yes ☐ No
   If yes, please provide carrier information.
6. Prior carrier:

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made or Occurrence	Retroactive Date (Claims Made Only)
			$		
			$		
			$		
			$		

SECTION IX - AUTOMOBILE

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 X - 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 XI – 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? $_____

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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 the Applicant require? $_____

SECTION XII – CLAIMS MADE

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 XIII – 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 Offenders	%

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

2. Does the Applicant maintain all medications in a locked area? ☐ Yes ☐ No
3. Do the Applicant's intake procedures include a physical examination? ☐ Yes ☐ No
4. 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:

5. 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: _____
6. Does the Applicant perform any "rapid detox" or any detox under general anesthesia? ☐ Yes ☐ No
7. 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 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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DIRECTORS & OFFICERS / EMPLOYMENT PRACTICE LIABILITY

THIS SECTION IS AN APPLICATION FOR A CLAIMS MADE POLICY.
PLEASE READ YOUR POLICY CAREFULLY.

DIRECTORS & OFFICERS LIABILITY INFORMATION

1. Does the Applicant have a tax-exempt status under the U.S. Internal Revenue Code? ☐ Yes ☐ No
   If no, provide an explanation:

2.

FINANCIAL INFORMATION	CURRENT FISCAL YEAR	PREVIOUS FISCAL YEAR
Total Assets:	$	$
Net Assets / Fund Balance:	$	$
Annual Revenue:	$	$
Net Revenue:	$	$

3. Provide a list of all direct and indirect subsidiaries or any other entity or organization the Applicant controls:

Name / Type of Business	Percent the Applicant Owns/Controls	Date Created / Acquired	For Profit / Non-Profit
I.E.: ABC Foundation / Charitable Foundation	100%	01/01/2000	Non-Profit
	%		
	%		
	%		

☐ Additional entities listed by attachment

4. Has the Applicant or any person proposed for coverage herein been the subject of, or involved in, any of the following in the past five (5) years? If yes, please attach details. ☐ Yes ☐ No

   Any disciplinary action by any regulatory agency or association? ☐ Yes ☐ No
   Any administrative proceeding charging violation of a federal or state law or regulation? ☐ Yes ☐ No
   Any other criminal actions? ☐ Yes ☐ No

5. In the past 24 or next 12 months has the Applicant been, or anticipate being involved in any merger, acquisitions or consolidation with another entity? ☐ Yes ☐ No
   If yes, please attach details.

EMPLOYMENT PRACTICE LIABILITY INFORMATION:

1. Please provide the following employee count information:
   U.S. based employees: _____
   Total Full-Time: _____ Total Part-Time: _____
   Volunteers: _____ Temporary: _____
   Leased: _____ Total Non U.S. based employees: _____
   TOTAL SUM OF ABOVE: _____

2. Has a reduction in employees or change in of status occurred in the past 12 months or is anticipated in the next 12 months?
   Voluntary: _____ Involuntary: _____ Layoffs: _____

3. Does the Applicant have an employment handbook that includes an “At Will” statement? ☐ Yes ☐ No

4. Does the Applicant use an employment application for every potential employee? ☐ Yes ☐ No

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5. Does the Applicant use outside employment counsel for employment advice? ☐ Yes ☐ No

6. Does the Applicant have a full time, dedicated human resource staff? ☐ Yes ☐ No

7. Total number of current employees with annual compensation greater than $100,000:_____

CURRENT COVERAGE:

COVERAGES	Insurance Company	Limit of Liability	Deductible	Policy Effective Dates	Premium
D & O		$	$		$
EPLI		$	$		$
Fiduciary		$	$		$
Workplace Violence		$	$		$
Internet Liability		$	$		$

WARRANTY INFORMATION:

1. With respect to this coverage, has any Underwriter refused, canceled or non-renewed coverage? **(Not Applicable in Missouri)** ☐ Yes ☐ No
   If yes, please provide details:

2. Has the Applicant given written notice under the provisions of any prior policies providing similar insurance or claims, or of specific facts or circumstances which might give rise to a claim being made against any person or entity applying for this insurance?
   If yes, complete a Claim Supplemental for each incident. ☐ Yes ☐ No

3. No person applying for this coverage is aware of any facts or circumstances which he or she has reason to suppose might give rise to a future claim that would fall within the scope of any of the proposed coverages for which the Applicant has applied, except: ☐ None or as noted below.

With regard to questions 2. and 3., it is understood and agreed that if any such claim, act, error, omission, dispute or circumstance exists, then such claim and/or claims arising from such act, error, omission, dispute or circumstance is excluded from coverage that may be provided under this proposed insurance and, further, failure to disclose such claim, act, e rror, omission, dispute or circumstance may result in the proposed insurance being void, and/or subject to rescission.

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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

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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)