PHILADELPHIA INSURANCE COMPANIES

A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

RESIDENTIAL CARE SUPPLEMENTAL APPLICATION

Applicant Name:
E-mail Address: Website Address:
For-Profit Non-Profit Annual Budget: $ Annual Payroll: $
SIC code: FEIN:
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:
Year business established: Years under present management:
Name of executive director / administrator: Number of years at facility:
Risk Management Contact: Phone: Email:

REQUIREMENTS FOR SUBMISSION

- Completed ACORD applications
- Copy of facility evaluation
- Copy of the current license
- Currently valued company loss runs for this policy period plus three year's prior

SECTION I – GENERAL INFORMATION

1. Are ALL operated residential facilities licensed? Yes No
2. Has Applicant's license ever been suspended, revoked, or placed under conditional status? Yes No
3. Date of last state inspection:
   Any inspection violations/deficiencies noted? Yes No
   Provide date compliance completed:
4. Have there been any claims that allege negligence or failure to comply with any regulatory / license guideline? Yes No
   If yes, please explain on a separate sheet of paper.
5. Any mergers or operations under another name within the past five (5) years? Yes No
6. Primary funding source: Private SSI/SSP Other:
7. Does the Applicant operate any locations not included in this application? Yes No
   If yes, describe:
8. List all association memberships or affiliations:

SECTION II – MANAGEMENT PRACTICES

1. Does the Applicant have sign in/out procedures for:
   Staff? Yes No Clients/Residents? Yes No Visitors/Public? Yes No
2. Describe precautions utilized to prevent unauthorized access to facility(s):
3. Service Level / Client to Staff Ratio Definitions (select all that apply):
   These clients do not live in licensed residential care homes as they are very high functioning. Most hold jobs or attend day programs. (Level 1 – CA Only)
   6 to 1 staff ratio (6 residents to 1 staff person minimum). Residents want or need a little supervision – only reminders to do things. Supervision for safety reasons only. Most residents attend day programs or attend sheltered workshops. (Level 2 – CA Only)
   3 to 1 staff ratio. Behavior issues maybe involved (i.e. not listening, assistance with physical needs such as toileting, bathing). Most residents attend day programs or sheltered workshops. (Level 3 – CA Only)
   Direct assistance needed for physical and/or behavioral issues. Most residents attend day programs or sheltered workshops. Care, supervision, and professionally supervised training for persons with deficits in self-help skills, and/or severe impairment in physical coordination and mobility, and/or severely disruptive or self-injurious behavior. Service level 4 subdivided into levels 4 (a) through 4(i), in which staffing levels are increased to correspond to escalating severity of disability levels. (Level 4 – CA Only)
      Has a 3 to 1 staff ratio (additional hours may be required if over 3 residents in home (Level 4 (a-e) – CA Only)
      Has a 2 to 1 staff ratio (Level 4 (f-i) – CA Only)

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SECTION III – RESIDENTIAL FACILITIES

(photocopy this section for each additional location)

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

1. Annual number of clients by age group:
   Less than 18: 18 - 35: 36 - 65: Over 65:
   Average Occupancy:
2. Annual number of clients by disability:
   24-hr Constant Care Required: Alzheimer's/Dementia: Blind: Deaf:
   Developmental Disability: Drug/Alcohol: Emotional/Behavior:
   Intellectual Behavior: Non-Ambulatory: Traumatic Brain Injury:
3. Is specific training provided for all staff caring for these ailments? Yes No
4. Does the Applicant train staff to recognize the need for increased level of care and have procedures in place for properly reassigning clients to more suitable facilities? Yes No
5. Resident elopement/unauthorized leave prevention (check all that apply):
   Exit doors locked to residents Wristband sensor w/alarm Exit doors alarmed to residents
6. How often are residents checked or monitored to ensure that they are at the facility or have returned to the facility?
7. Specify number of: Male: Female: Co-ed:
8. Are residents separated? Yes No
   How are they separated?
9. Average length of stay:
10. Total number of rooms: Number of bedrooms:
11. Does a physician screen clients prior to admission? Yes No
12. Does the Applicant require a signed release form for the release of records to other individuals or institutions? Yes No
13. Are residents primarily responsible for their own basic personal care including bathing, dressing, eating, and restroom aide? Yes No
14. Is the staff trained in non-violent crisis intervention? Yes No
    If yes, which protocol?
15. What type of method does the Applicant use for de-escalation?
    Is it approved? Yes No
16. What is the Applicant's physical restraint policy?
17. What is the ratio of resident to staff: Day: Night:
18. What procedures are in place for clients who are permitted to leave the premises without supervision?
19. How many visits per month are made by a caseworker to a resident?
20. How does the Applicant provide for the resident's privacy and individual security?
21. How often are rooms inspected?
    Who inspects the room?
    Does the Applicant have written procedures? Yes No
    Does the Applicant keep a checklist? Yes No
22. How often are bed checks done? Random Scheduled
23. How is staff monitored?
24. Are there security cameras monitoring operations and residents? Yes No
25. Are resident's doors ever locked from the outside? Yes No

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26. Are residents allowed to cook their own meals? Yes No
If yes, in: Private or Common cooking areas
27. Does the Applicant own or operate a Nursing Home or Assisted Living Facility? Yes No
If yes, please explain:

28. Is there a pool? Yes No
If yes, who uses the pool: Visitors Staff Clients/Residents
Is the pool completely fenced in with a self-locking gate? Yes No
If yes, what is the height?
Is there a diving board? Yes No
Is the staff trained in water safety? Yes No

SECTION IV – PROFESSIONAL LIABILITY / STAFF

1. Does the Applicant create written job descriptions for each employee and share with staff? Yes No
2. Does the Applicant train and require all staff to report all incidents to management? Yes No
Is a written record of all incidents kept? Yes No
Does management investigate each incident and record findings in writing? Yes No
3. Does the Applicant's current insurance program include professional liability? Yes No
If yes, is it: Occurrence or Claims Made – Retro Date: Limit: $
Carrier: Effective Date:
4. What is the staff turnover ratio for the last twelve (12) months?
5. 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					

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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.

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 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.**

SECTION V - CONSULTANTS/INDEPENDENT CONTRACTORS

1. Please indicate which of the following contracted service providers are utilized:
   Dentist Nurse Practitioner Physicians Other:
   Home Health Aides Optometrist Psychiatrist
2. Are there written agreements with independent contractors? Yes No
3. Are certificates of malpractice/liability insurance obtained and maintained for all contracted service providers (independent contractors)? Yes No
4. Please indicate the limits of liability: $

SECTION VI – LIFE SAFETY

Do all the Applicant's facilities (buildings) have the following life safety features?

1. Fire alarms? Yes No
2. Smoke detectors: Hardwired Yes No Battery operated Yes No
3. Emergency lighting? Yes No
4. Ceiling sprinklers? Yes No
5. 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
6. Are evacuation routes posted throughout the building? Yes No
7. In the event of an evacuation, has the Applicant established a central meeting point outside the building? Yes No
8. Are exit signs illuminated? Yes No
9. How often are the fire drills held?
10. Are there at least two exit doors per building? Yes No
11. Are exit doors equipped with panic hardware? Yes No
12. Is smoking permitted inside the premises? Yes No
13. Are any non-ambulatory residents located above the 1st floor? Yes No
    If yes, provide number of residents and which floor they reside on.
14. Does the property have aluminum wiring? Yes No
    If yes, has it been retrofitted with one of the following PHLY approved connectors by a licensed Electrician? (indicate which one): COPALUM? Yes No AlumiConn? Yes No

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SECTION VII – ABUSE & MOLESTATION 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
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 VIII - AUTOMOBILE N/A

1. Are all vehicles listed on the ACORD application registered to the applicant? Yes No
   If no, explain:
2. Are vehicles for more than 8 passengers equipped with an audible backup warning service? Yes No
3. How many drivers use personal vehicles for business? Volunteers: F/T*: P/T**:
   *F/T = Full Time – over 20 hours per week / **P/T = Part Time – up to 20 hours per week
4. Does the Applicant require employees and volunteers to carry and show evidence of personal insurance if they use their personal vehicle in the business? Yes No
5. What limits are required? $
6. Does the Applicant run MVRs on employees? Yes No If yes, how often?
7. Does the Applicant have a driver safety training program? Yes No
8. Are all drivers at least 21 years of age? Yes No
9. Do any drivers between the ages of 21 and 25 operate vehicles with eight (8) passenger seating capacity or greater? Yes No
10. Does the Applicant have a formal vehicle maintenance program in effect? Yes No
11. Does the Applicant transport clients? Yes No
    a. Is training provided for new employees and/or volunteers prior to their transporting clients? Yes No
    b. Are vehicles checked after passengers disembark to make sure no one is left behind? Yes No
    c. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger? Yes No
    d. Does the Applicant require seat belts to be worn by all passengers? Yes No
12. Does the Applicant transport clients/consumers for other private or government agencies? Yes No
    If yes, please explain:

    If yes, for a fee? 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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SECTION IX – 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:

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SECTION X - 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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