Human Services Program

Commonwealth Underwriters Ltd.
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GENERAL APPLICATION

All questions must be fully and completely answered. If there is not enough room in the space provided, a separate page(s) may be attached. Please mark "N/A" any question that does not apply to your operation. Complete each Supplemental Application depending upon the service your Organization provides. If a Supplement is not completed, no coverage will be granted for that service.

NOTE: In applying for coverage, applicant agrees that, in the event of covered losses, applicant will be required to be defended by the Company's appointed attorneys and that the deductible shall apply to loss including (whether or not loss payment is made) adjusting expenses, investigation costs, and legal fees. If however, applicant elects to handle a claim without in any way involving the Company's attorney, then no coverage for such claim is afforded the applicant under the Policy.

Include the following with this completed and signed application:

- **Five (5) years currently valued hard copy loss runs**
- **Completed and signed Acord applications**
- **Completed and signed supplemental applications**
- **Descriptive brochures, publications & newsletters**
- **Drivers list including MVRs on all primary drivers**

Section I INSURED INFORMATION

1. GENERAL INFORMATION

Name of Applicant:_____

Address: _____

City/State/Zip:_____

Phone Number:_____ Fax Number:_____

Contact Person for Inspection:_____ E-Mail:_____

Website:_____

Desired Effective Date of Coverage:_____

Agent/Broker Name:_____ Address:_____

2. List all subsidiaries (attach a list if more space is required):

Name	Type of Operation	% of Ownership	Date Acquired	Domestic or Foreign

Do you wish coverage to include all subsidiaries? ☐Yes ☐No

3. APPLICANT IS:

Non Profit: ☐ For Profit: ☐

Annual Budget:_____ Years Operational:_____

Description of your operations: _____

_____

_____

3. APPLICANT IS (Continued):

Servicing population of:

Community Services (Complete Supplement #1)	_____%
Developmentally Disabled (Complete Supplement #1)	_____%
Adoption (Complete Supplement #2)	_____%
Foster Care (Complete Supplement #2)	_____%
Substance Abuse/Addiction Programs (Complete Supplement #3)	_____%
Behavioral Health (Complete Supplement #4)	_____%
Youth Residential (Complete Supplement #4)	_____%
Commercial Day Care (Complete Supplement #5)	_____%

PLEASE COMPLETE THE APPROPRIATE SUPPLEMENTAL APPLICATION BASED UPON ABOVE RESPONSE

1. If you provide any services to people that are incarcerated or recently released from incarceration, please provide details of services provided:_____

_____

2. Do you have any alternative to incarceration or lock down facilities? ☐ Yes ☐No

3. Associations or Organizations that applicant is member of _____

4. Applicant is an accredited by:

JCAHO ☐	Expiration Date_____
CARF ☐	Expiration Date_____
COA ☐	Expiration Date_____
Other_____	Expiration Date_____

5. Is applicant or any of its services licensed by the state in which it operates? ☐Yes ☐No

If yes, name the authority:_____

6. Has license ever been suspended or revoked: ☐Yes ☐No
If yes, attach copy of the Authority's report.

4. STAFFING:

	# of EMPLOYEES		**# of NON EMPLOYEES**	
Profession	Full Time	Part Time	Volunteers	Consultants
Psychiatrists (M.D.s)*	_____	_____	_____	_____
Other Physicians (M.D.s)*	_____	_____	_____	_____
Psychologists(Ph.D.)*	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Medical Director**	_____	_____	_____	_____
Ind. Licensed Practitioner	_____	_____	_____	_____
R.N.	_____	_____	_____	_____
L.P.N./L.V.N.	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Speech/Occ. Therapist	_____	_____	_____	_____
Nutritionist	_____	_____	_____	_____

4. STAFFING (Continued):

Profession	# of EMPLOYEES Full Time	Part Time	# of NON EMPLOYEES Volunteers	Consultants
Outdoor Adv. Staff	_____	_____	_____	_____
Teachers	_____	_____	_____	_____
Teachers' Aide	_____	_____	_____	_____
Home Health Staff	_____	_____	_____	_____
Admin/Clerical	_____	_____	_____	_____
Maintenance/Housekeeping	_____	_____	_____	_____
Drivers	_____	_____	_____	_____
Others (Specify Position)	_____	_____	_____	_____

***Please List Names on a separate sheet**

**** NOTE: Do not include if counted as Psychiatrists or Psychologists**

5. OPERATIONS/PROCEDURES

A. Do you have contracted or employed physicians? ☐Yes ☐No
If yes, please provide a claims history for all.

B. Do employee/non-employee psychiatrists, physicians, psychologist maintain individual medical malpractice coverage?
☐Yes ☐No Required Limits:_____

C. Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offense? ☐ Yes ☐No

D. Do you obtain criminal background records, that check at least 10 years of data from 50 states, on ALL employees and non-employees before start date? ☐ Yes ☐No
If No, please explain

_____

Do you verify employment related references? ☐ Yes ☐No If yes, by telephone? _____ in person?_____

F. Does your organization conduct a personal interview? ☐ Yes ☐No

G. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a client/child reports someone molested/abused him or her? ☐Yes ☐No

H. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? ☐Yes ☐No

I. Do you have a crisis management plan for dealing with staff personnel, victim, parents authorities and media if you have an incident of abuse? ☐Yes ☐No

J. Have you ever had an incident/allegation of abuse that was found to be substantiated? ☐Yes ☐No
If Yes, please describe incident(s) and the changes that were implemented to prevent future occurrences

_____
_

K. Have you ever had an incident/allegation of abuse that resulted in a claim? ☐Yes ☐No

If yes, in a separate attachment, please describe in detail each incident and include:
1. Date allegations were made
2. Number of claimants
3. Date of settlement
4. Defense costs
5. Indemnity costs

L. Is ANYONE applying for insurance under this policy aware of any state, federal, local code or professional violations, unethical misconduct, incompetence or negligence? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

M. Is ANYONE applying for insurance under this policy aware of any circumstances involving sex or sexual abuse/molestation with any patients, former patients or relatives thereof? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

N. Does ANYONE applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

O. Does ANYONE applying for insurance under this policy use paddling, physical striking, withholding of food, shelter or bathroom facilities or any such methods as a treatment/discipline technique? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

P. Does the applicant enlist the services of:

a. Volunteers (a volunteer is someone who does work or provides services for the applicant, but is not an employee and includes unpaid consultants and board members)? ☐Yes ☐No

b. Temps/Independent Contractors? ☐Yes ☐No

If yes, do all go through the same screening & training process as employees? ☐Yes ☐No
If no, please explain process and why different_____

Q. Do you contract with another facility for additional beds? ☐Yes ☐No
If yes, number of beds:_____
PLEASE PROVIDE A COPY OF THE CONTRACT

SECTION II PRIOR CARRIER INFORMATION

COVERAGE	COMPANY	LIMITS	PREMIUM	EFF. DATE	RETRO DATE
PROFESSIONAL LIABILITY					
GENERAL LIABILITY					
EXCESS AND/OR UMBRELLA					
AUTOMOBILE					
PROPERTY					
CRIME					
Computer/EDP					

1. If no insurance exists, is this a new venture? ☐ Yes ☐No
If not a new venture, please explain why no insurance coverage was in place_____
_____

2. Is expiring Professional Liability coverage on a claims made policy? ☐ Yes ☐No
If yes, please provide Retroactive Date:_____
PLEASE PROVIDE PROOF OF UNINTERRUPTED CLAIMS MADE COVERAGE

Do you desire prior acts coverage: ☐ Yes ☐No

3. Has the applicant had ANY claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past five (5) years? ☐ Yes ☐No
IF YES, PLEASE COMPLETE CLAIM HISTORY SUPPLEMENT #6 AND ATTACH HARD COPY LOSS RUNS PROVIDED BY THE APPROPRIATE CARRIER.

IMPORTANT NOTICE

APPLICANT WARRANTS THAT ITS PROPERTIES ARE IN COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS FOR THE PERSONS WITH PHYSICAL HANDICAPS. APPLICANT UNDERSTANDS AND ACCEPTS THAT PREMIUM IS FULLY EARNED AT INCEPTION. APPLICANT ALSO UNDERSTAND THAT THIS INSURANCE IS BEING APPLIED FOR WITH AN INSURER THAT IS NOT LICENSED BY YOUR STATE'S INSURANCE DEPARTMENT. IN CASE OF INSOLVENCY, PAYMENT OF CLAIMS MAY NOT BE GUARANTEED BY YOUR STATE'S GUARANTEE FUND.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY SUBMITTED IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION DOES NOT BIND THE APPLICANT TO BUY, OR THE COMPANY TO ISSUE THE INSURANCE, BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT AND SHOULD A POLICY BE ISSUED, IT WILL BE ATTACHED TO AND MADE A PART OF THE POLICY.

THE UNDERSIGNED APPLICANT DECLARES THAT THE STATEMENTS SET FORTH IN THIS APPLICATION ARE TRUE. THE APPLICANT FURTHER DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE TIME WHEN THE POLICY IS ISSUED, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENT TO BIND THIS INSURANCE.

IF AND WHEN A POLICY IS ISSUED THIS APPLICATION IS ATTACHED TO AND MADE A PART OF THE POLICY, SO IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED IN DETAIL. THE APPLICANT HEREBY ACKNOWLEDGES THAT HE/SHE IS AWARE THAT BY SIGNING BELOW WHERE INDICATED, THAT THIS SIGNED STATEMENT WILL BE ATTACHED TO THE POLICY.

NOTICE TO ARKANSAS APPLICANTS: "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 FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "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."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "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."

NOTICE TO FLORIDA APPLICANTS: "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."

NOTICE TO KENTUCKY APPLICANTS: "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."

NOTICE TO LOUISIANA APPLICANTS: "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 FINES AND CONFINEMENT IN PRISON."

NOTICE TO MAINE APPLICANTS: "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."

NOTICE TO MINNESOTA APPLICANTS: "A PERSON WHO SUBMITS AN APPLICATION OR FILES CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "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."

NOTICE TO NEW YORK APPLICANTS: "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, 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."

NOTICE TO OHIO APPLICANTS: "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."

NOTICE TO OKLAHOMA APPLICANTS: "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."

NOTICE TO PENNSYLVANIA APPLICANTS: "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."

NOTICE TO VIRGINIA APPLICANTS: "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."

NOTICE TO WEST VIRGINIA APPLICANTS: "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 FINES AND CONFINEMENT IN PRISON."

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT (1) THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND (2) IF THE INFORMATION SUPPLIED IN THIS APPLICATION OR SUPPLEMENTAL APPLICATIONS CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AGREEMENT TO BIND THE INSURANCE. FURTHERMORE, SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE.

DATE:_____ SIGNATURE:_____
(APPLICANT)

TITLE:_____

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