Patriot Insurance Agency, Inc.
DBA: Arizona Patriot Insurance Agency, Inc. in CA, NC, ND, NY
P.O. Box 1298
Sonoita, AZ 85637-1298
Phone: 520 455-9252
Fax: 520 455-9358
Toll Free Number: 800 859-2724
Email: wecare@patriot-insurance.com
www.patriot-insurance.com

DIRECTIONS FOR OBTAINING A QUOTATION

Please find enclosed the application regarding Package Liability coverage to be completed. Follow these easy steps to expedite your request for a quotation:

1. Make sure that all questions are answered completely and as accurately as possible. Missing information will delay your quotation.

2. Make certain you sign the application. (Signing does NOT obligate you to purchase the coverage.)

3. Copies of all Advertisements:
    a. Yellow Pages, Newspapers, Church Bulletins, Brochures, TV/Radio

4. A copy of the membership for all affiliations with a National Organization.

5. Should you have prior coverage, please provide current loss runs (claims history report from carrier).
    a. If no prior insurance, forward the Executive Director's resume.

6. Board of Director Guidelines

7. Client Referral Guidelines

8. Personnel Procedures

9. Hired and Non Owned
    a. Motor vehicle reports (MVRs)
    b. Copies of personal auto policy declaration pages.

Upon receipt of the above information, a quotation is generally available within fifteen (15) business days.

Should we be of further assistance, please contact our Underwriting Department at 800.859.2724. Thank you.

Please forward all the above information to our agency via mail, fax or email.

Thank you for allowing us to service your insurance needs and we look forward to working with you in the near future.

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COMMUNITY SERVICE INSURANCE PROGRAM APPLICATION

APPLICANT INFORMATION SECTION

Organization's Legal Name:	
Name of Director/Contact:	
Mailing Address: (*Including City, State and Zip)*	
Physical Location Address: (*Including City, State and Zip)*	
Telephone Number:	
Fax Number:	
Email Address:	
Web Page Address:	
Federal Identification Number:	

WARRANTY

Please understand that your answers and responses throughout this application serves as a warranty. Your completed application will become part of the wording and conditions of your organization's policy. Therefore, any misrepresentation or omissions made on this application may void any or all coverage benefits under these policies. Your signature below acknowledges that you understand this warranty and certifies your responses to be true and correct. Revocable Proxy. The undersigned hereby appoints Roberta Renzi and Erika Hill of the Board of Directors of The International Association of Community Service Organizations (the ñAssociationò), and each of them, as proxy, with full power of substitution, to cast all votes that the undersigned Member is entitled to cast at any meeting of the Association and to act with respect to all votes that the undersigned would be entitled to cast until the earlier of the time that this proxy is revoked or three years from the date that this instrument is executed and delivered to the Association.

Applicant's Signature _____ Date: _____

Applicant's Name *(printed)* _____ Title: _____

LOSS EXPERIENCE SECTION

Over the last four years have any claims, incidents or lawsuits been brought against your organization or affiliated organization? **YES*** ☐ **NO** ☐

**If yes, please attach detailed claim information with the date of loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.*

This application form duly completed, together with any supplementary information must be signed in ink by the Executive Director or Board President. **ALL QUESTIONS MUST BE COMPLETED, SIGNED AND ANY APPLICABLE INFORMATION PRESENTED BEFORE A QUOTE CAN BE OFFERED.**

COMMUNITY SERVICE INSURANCE PROGRAM APPLICATION

DESCRIPTIONS OF OPERATIONS SECTION

Please describe your organization's operation, purpose, and daily functions.
(Please use a separate sheet of paper if more space is required.)

1. Are you affiliated with a National Organization? If yes, please indicate _____

2. Do you have a maternity home or operate an overnight facility? **YES** ☐ **NO** ☐
   a. ** If yes, Are you licensed by the state(s) in which you operate? **YES** ☐ **NO** ☐
   (Please attach copy of license and latest inspection.)
   b. Is it renewed: ☐ Annually ☐ Semi-Annually ☐ Other: _____

3. Are you a multi-location organization? **YES*** ☐ **NO** ☐
   If Yes, please attach (on a separate sheet of paper) a schedule which will contain the following information for each location: (1) the physical location address, (2) the hours of operation per week including weekends if applicable (3) a description of the services provided to your clients.

4. Average number of hours per week the main location is open: _____

5. Average number of Employees: _____ Average number of Volunteers: _____

6. Average number of those providing counseling _____ (Counselors)

7. How many new personnel were added + _____ or left - _____ your staff last year.

8. Are you organized as a 501(c)(3) nonprofit organization? **YES** ☐ **NO** ☐

9. Name of present insurance carrier for General Liability and Professional Liability:

   _____

   Expiration Date: _____ Premium: _____

10. Effective Date Organization Began Service: _____ Date of Incorporation of your Organization: _____

COMMUNITY SERVICE INSURANCE PROGRAM APPLICATION

PROFESSIONAL LIABILITY SECTION

1. Is there an established training and continuing education program provided for all counselors? **YES** ☐ **NO** ☐
   If Yes, does the training and education provided to your counselors teach counseling with a loving/factual approach to your clients? Specifically, are the harsh techniques of employing the pressures of guilt or mental anguish rejected as an appropriate counseling procedure? **YES** ☐ **NO** ☐

2. How often does the Director conduct a performance review with the individual counselors? _____
   Is this review done in writing? **YES** ☐ **NO** ☐

3. Do you make referrals to an adoption agency? **YES** ☐ **NO** ☐
   If Yes, do you have a Hold Harmless Agreement signed by your client? **YES** ☐ **NO** ☐

4. Do you have a licensed physician practicing at your location? **YES** ☐ **NO** ☐

5. Do the physicians you refer your clients to carry their own Professional Liability Insurance? **YES** ☐ **NO** ☐
   If Yes, do you require proof of coverage? **YES** ☐ **NO** ☐

6. Do you provide rape, sex abuse, suicide, spouse abuse, substance abuse, or other extensive social service counseling?
   YES** ☐ **NO** ☐

   ***If so, this Insurance Program **does not** cover the exposures associated with operating these extensive social service operations as described above. We have a separate program available to cover these exposures. (Please call for information.)*

7. Are you a Pregnancy Care Medical Clinic? **YES**** ☐ **NO** ☐
   **A Pregnancy Care Medical Clinic provides sonograms, physical examinations, and other select medical services.
   ***If Yes, this Insurance Program **does NOT** cover these exposures. A separate policy may be added to cover these additional exposures. (Please call for information.)*

8. Please provide the annual number of client contacts (visits, call-in etc.) for the following services:

	# of Visits
Pregnancy counseling: Individual	_____
Pregnancy counseling: Group	_____
Family/Independent Living Skills Training	_____
Adoption / Foster care counseling* *(*Other than Options Counseling)*	_____
Adoption / Foster Care Referrals	_____
Other types of counseling *(describe below)*	_____

_____

_____

_____

COMMUNITY SERVICE INSURANCE PROGRAM APPLICATION

GENERAL LIABILITY SECTION

1. Does your location maintain dry floors, unobstructed walkways and halls during operating hours in order to reduce the exposure to accidental slip and fall claims?
   YES ☐ **NO** ☐

2. Many landlords require General Liability limits of $1,000,000 per location. Does this amount adequately meet the requirements of your lease?
   YES ☐ **NO*** ☐ ***If not, what Liability Limit is required?** _____

***Program automatically includes $1,000,000 General Liability Limit. Additional excess Umbrella limits may be purchased. Please call for an application.*

3. **YOUR ADDITIONAL INSUREDS**: Insurable Interest – check the box that applies:

   Name: _____ ☐ Funding/Placement ☐ Landlord
   ☐ Contract/Service
   Address: _____ ☐ Other: Please Describe: _____

   _____

   Name: _____ ☐ Funding/Placement ☐ Landlord
   ☐ Contract/Service
   Address: _____ ☐ Other: Please Describe: _____

   _____

4. Do you lease or sub-lease to others any portion of the locations scheduled on the application? **YES** ☐ **NO** ☐
   a. If yes, do you require that your tenant carry liability insurance for the Occupancy? **YES** ☐ **NO** ☐
   b. If yes, how do you make sure the coverage is maintained? _____

5. Is care taken in planning and coordinating your fund raising activities? Specifically, do you require all vendors or equipment suppliers to provide a Certificate (proof) of Insurance, prior to remitting payment for their services? **YES** ☐ **NO** ☐

6. In the past have you safely planned and managed crowd control, movement, and overflow parking during your events?
   YES ☐ **NO** ☐

7. When you hold a meeting or event is care taken when using property of a Third Party (such as: church, school, etc?)
   Yes ☐ **No** ☐

8. Are volunteers, employees, or those working at your center covered by Workers Compensation Insurance or Personal Health Insurance or Group Medical Insurance?
   YES ☐ **NO** ☐

COMMUNITY SERVICE INSURANCE PROGRAM APPLICATION

ADVERTISING LIABILITY SECTION

1. Please indicate if you advertise in the newspapers ☐ , yellow pages ☐, church bulletins ☐ or other print media ☐?

   YES* ☐ **NO** ☐

   *If Yes, what classified heading(s) are used for your ads?

   ☐ 1. Abortion
   ☐ 2. Abortion Services
   ☐ 3. Clinics
   ☐ 4. Family Planning/Birth Control
   ☐ 5. Social Services
   ☐ 6. Abortion Alternatives
   ☐ 7. Pregnancy Counseling
   ☐ 8. Other – please describe: _____

2. Do you advertise on the radio ☐ or television ☐ ? ** **YES** ☐ **NO** ☐

   If either media is utilized, does the script include any ambiguous terminology while describing exactly what services you provide? **YES** ☐ **NO** ☐

PLEASE INCLUDE A COPY OR SCRIPT OF YOUR RADIO OR TELEVISION ADVERTISEMENT.

HIRED AND NON-OWNED AUTO LIABILITY SECTION

(Subject to Underwriting Approval)

1. Do you provide transportation for your clients? **YES** ☐ **NO** ☐
2. Do employees, workers, or volunteers use their vehicles on behalf of the organization? **YES** ☐ **NO** ☐

It is management's responsibility to establish and enforce drive selection criteria

3. Do you order Motor Vehicle Reports (MVR) annually for all employees and volunteers driving their vehicles on your behalf? **YES** ☐ **NO** ☐
4. Do you have a procedure for evaluating MVR's to identify unacceptable/marginal drivers? **YES** ☐ **NO** ☐
5. Does the Organization verify that the employees or volunteers have their own vehicles properly insured? **YES** ☐ **NO** ☐

PLEASE NOTE: Evidence of adequate insurance must be updated annually.

COMMUNITY SERVICE INSURANCE PROGRAM APPLICATION

OPTIONAL: PHYSICAL & SEXUAL ABUSE SECTION

(Subject to Underwriting Approval & Additional Premium)

1. Does your state permit you to do criminal background investigations on prospective employees/volunteers?
   YES ☐ **NO** ☐

   a. If yes, do you routinely request and receive such background investigations? **YES** ☐ **NO** ☐

   b. If yes, how often? _____

2. Do you verify employment related references? **YES** ☐ **NO** ☐

3. Do you verify educational requirements? **YES** ☐ **NO** ☐

4. Do you conduct a personal interview? **YES** ☐ **NO** ☐

5. Are professional licenses checked for employees/volunteers? **YES** ☐ **NO** ☐

6. Do you provide new employee orientation? **YES** ☐ **NO** ☐

7. Do you discuss at staff orientations, physical and sexual abuse issues, how to recognize the signs and what to do if a client reports someone molested him/her? **YES** ☐ **NO** ■

8. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients? **YES** ☐ **NO** ☐

9. Do you have a crisis management plan for dealing with staff, victim, parents, authorities and media if you have an incident of abuse? **YES** ☐ **NO** ☐

10. Have you ever had an incident which resulted in an allegation of sexual abuse? **YES** ☐ **NO** ☐

11. Was a claim ever made against you? **YES** ☐ **NO** ☐

Additional Remarks Section: