

Patriot Insurance Agency, Inc.

DBA: Arizona Patriot Insurance Agency, Inc. in CA, NC, ND, NY

P.O. Box 17026

St. Petersburg, FL 33733

Toll Free Number: 800 859-2724

Fax: 520 842-2978

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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P.O. Box 17026

St. Petersburg, FL 33733

Toll Free Number: 800 859-2724

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Email: wecare@patriot-insurance.com

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COMMUNITY SERVICE INSURANCE PROGRAM APPLICATION

APPLICANT INFORMATION SECTION

Organization's Legal Name:	
Name of Director/Contact:	
Mailing Address: <i>(Including City, State and Zip)</i>	
Physical Location Address: <i>(Including City, State and Zip)</i>	
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.

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.*

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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 of 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:

	<u># of Visits</u>
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)	_____

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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 INSURED:** 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

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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?

- | | |
|---|--|
| <input type="checkbox"/> 1. Abortion | <input type="checkbox"/> 6. Abortion Alternatives |
| <input type="checkbox"/> 2. Abortion Services | <input type="checkbox"/> 7. Pregnancy Counseling |
| <input type="checkbox"/> 3. Clinics | <input type="checkbox"/> 8. Other – please describe: |
| <input type="checkbox"/> 4. Family Planning/Birth Control | |
| <input type="checkbox"/> 5. Social Services | |

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.

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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: