



**Nonprofit and Human Services  
Supplemental Questionnaire**

Name of Organization		Date Organization Founded:	
Street Address:		Mailing Address:	
Website Address:		FEIN:	

**GENERAL INFORMATION I**

1. Does your organization provide or offer services or programs for?

Type of Clients:	Yes	No	# Clients
Psychotic disorders (e.g. schizophrenia, paranoia, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Mood disorders (e.g. bi-polar, mania, manic depressive)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Clients who are severely mentally ill, violent, or suicidal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cognitive disorders (e.g. delirium, dementia, Alzheimer's)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Clients who have a pyromania or fire starting disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Clients who have an eating disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Violent crimes, sex crimes, or offenders who act out sexually	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

**Organization's Activities and Services Offered:**

Psychiatric or Psychological care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Crisis intervention (hotline, inpatient, suicide, pregnancy, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medications prescribed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	International operations or international travel	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medications dispensed, injected, or administered	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Commercial lending, insurance, or handling client's money	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dental Care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Labor Unions, Political Lobbying, or Political Action Committees, Rallies, Civil Demonstrations, Protests	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Methadone treatment, detoxification or needle exchange	Yes <input type="checkbox"/>	No <input type="checkbox"/>	In-home services (e.g., ministry, counseling, tutoring, health-related, crisis response, intervention, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Adoption or foster placement	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Medical care (e.g. medical clinic or treatment, skilled nursing)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Housing subject to HUD inspection	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Alternative sentencing, incarceration, or involuntary treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Construction, Rehabs, Energy, Retrofits, Property Repair, etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Halfway houses or lock-down facilities	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**For any yes answers, please explain**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 2. Organization is licensed to sell alcoholic beverages?                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Any vehicle owned or used transports individuals/property for a fee? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Organization employs or contracts armed security personnel?          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Any buildings or locations more than 50% vacant/unoccupied?          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
- If yes to any item in 1-5, contact underwriting before submitting.**

**GENERAL INFORMATION II**

- 1. Describe Organization's Operations: \_\_\_\_\_
- 2. Number of Years Under Current Management: \_\_\_\_\_
- 3. List Programs or Services Offered Including Number of Clients Served:

Program Description	Number of Clients

- 4. Number of Clients, Students, or Members by age category:  
 0-5 \_\_\_\_\_ 6-14 \_\_\_\_\_ 15-18 \_\_\_\_\_ 19-62 \_\_\_\_\_ 63-75 \_\_\_\_\_ 76-85 \_\_\_\_\_ 86+ \_\_\_\_\_
- 5. Number of Full Time Employees: \_\_\_\_\_ Part Time Employees: \_\_\_\_\_  
 Number of Volunteers: \_\_\_\_\_ Board Members: \_\_\_\_\_

6. Is the organization accredited by any professional organization? Yes  No   
 If yes, list the accreditations and the awarding organization: \_\_\_\_\_

7. Is the organization or any location required to be licensed to operate? Yes  No   
 If yes, attach copies of all licenses and most recent inspection reports.

- a. Date of Last regulator inspection: \_\_\_\_\_
- b. Were any violations or deficiencies noted on last inspection? Yes  No   
 If yes, describe: \_\_\_\_\_

c. Has the organization's license ever been:

Suspended?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Revoked?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Made Provisional?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes, for any of the above, explain: \_\_\_\_\_

8. Has the organization discontinued any programs in the last five (5) years? Yes  No   
 If yes, please explain: \_\_\_\_\_

9. Does the organization intend to engage in any mergers and/or acquisitions with other entities in the near future? Yes  No   
 If yes, please explain: \_\_\_\_\_

10. Does the organization file an IRS form 990? Yes  No   
 If yes, provide copy of most recent IRS form 990.  
 If No, provide copy of most recent financial statement for organization.

11. Are the organization's financial statements audited by a CPA firm? Yes  No   
 If yes, provide copy of most recent audit.

12. Annual Revenues/Receipts: \_\_\_\_\_ Annual Expenses: \_\_\_\_\_  
 Current Reserves/Surplus: \_\_\_\_\_ Restricted Amount: \_\_\_\_\_

13. Does 25% or organization's funding come from one source? Yes  No   
 If yes, please explain: \_\_\_\_\_

14. Is accident insurance provided for volunteers, clients or members? Yes  No   
 If yes, complete below:

Carrier	Policy Number	Policy Term	Limits	Premium Paid by Org?	
				Yes <input type="checkbox"/>	No <input type="checkbox"/>

**15.** Does the organization ever rent to or allow others to use insured locations? If yes, complete below: Yes  No

Number of times per year facilities are rented or used by others: \_\_\_\_\_

Are renters/users required to provide proof of insurance? Yes  No

Are written lease or use agreements required? Yes  No

Agreement specifies renter/user responsible for security? Yes  No

Hold Harmless and indemnification provision in agreement? Yes  No

Is insured listed as Additional Insured on each renter/user's insurance policy? Yes  No

**16.** Does organization own or maintain outdoor playground equipment? Yes  No

If Yes, describe equipment and location: \_\_\_\_\_

**a.** Was equipment built by a commercial manufacturer? Yes  No

**b.** Was equipment installed by an insured contractor? Yes  No

**c.** Is equipment maintained by an insured contractor? Yes  No

If any no answers above, please explain: \_\_\_\_\_

**d.** Describe the underlying surface and depth of materials under the playground: \_\_\_\_\_

**SPECIAL EVENTS & LIQUOR LIABILITY**  Not Applicable

**1.** Does the organization host, sponsor, or cosponsor special events or fun raising events? Yes  No

How many special events or fundraisers are held by organization? \_\_\_\_\_

How many special events or fundraisers are sponsored by organization? \_\_\_\_\_

How many special events or fundraisers are co-sponsored by organization? \_\_\_\_\_

**2.** List all planned special events with dates and estimated number of attendees:

Description of Event	Number of Attendees	Gross Receipts	Receipts from Liquor Sales

If all special events cannot be listed above, please attach listing to questionnaire with all special events listed.

**3.** Do any of the following apply to the special events of the organization?

Fireworks or Pyrotechnics	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bounce Houses, trampolines, or slides	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Multi-Day Event	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rodeo, Horses or Livestock	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Attendance over 300	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Parades	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Athletic Games or Contests	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Firearms or Archery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aquatic or Water Events	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Concerts	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aircraft	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Armed Security Personnel	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Motorized Vehicles or Conveyances (Poker Runs, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Transportation of Participants or Volunteers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mechanical Rides	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Haunted House or Haunted Trail	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes answered to any of the above, please explain: \_\_\_\_\_

<b>4.</b>	Have any claims or incidents occurred at an event? If Yes, please explain: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>5.</b>	Do any special events involve the serving or sale of alcoholic beverages?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>6.</b>	Is the organization licensed to sell alcoholic beverages?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>7.</b>	Type of license you have for sale of alcohol: <input type="checkbox"/> Permit for event only <input type="checkbox"/> Annual liquor license <input type="checkbox"/> Alcohol served by caterer.		
<b>8.</b>	Gross annual alcohol sales: _____		
<b>9.</b>	Have written alcohol dispensing policies, guidelines, controls?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>10.</b>	Do any employees, volunteers, clients, or members serve alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<b>SEXUAL MISCONDUCT COVERAGE/LIMITS</b>	<input type="checkbox"/> <b>Not Applicable</b>
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Sexual Misconduct Coverage:  Occurrence    Claims Made    Retroactive Date: \_\_\_\_\_

Occurrence/Aggregate Limit:    \$50,000/\$100,000  
 \$100,000/\$300,000  
 \$250,000/\$500,000  
 \$500,000/\$1,000,000  
 \$1,000,000/\$3,000,000

<b>1.</b>	Does your organization have a written zero tolerance for abuse policy that is communicated to all employees and volunteers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.</b>	Does your organization have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if there is an incident of abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.</b>	Is unsupervised contact with clients, students, or members ever allowed?		
	<b>a.</b> For employees?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	<b>b.</b> For volunteers or members?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	<b>c.</b> For contracted staff or professionals?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If yes to any of the above, describe allowable unsupervised contact and the waiting period required before unsupervised contact is allowed: _____ _____		
<b>4.</b>	Has your organization or any of your representatives ever submitted a claim for sexual misconduct liability to any insurer? If yes, submit a detailed written explanation of the event.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>5.</b>	Have any of your organization's past or present employees, volunteers, or representatives ever received a report, a complaint, an allegation, ever been charged, convicted, had a claim for damages submitted against, or sued in civil court for any type of sexual misconduct? If yes, identify the person and submit a detailed written account.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>6.</b>	Does your organization or any of your representatives or contractors have any investigation or inquiry pending at the time of this application, or knowledge of any information which may lead to an investigation or inquiry, regarding an event or occurrence of sexual misconduct involving your organization, or your officers, directors, trustees, employees, or volunteers? If yes, submit a detailed written account.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>7.</b>	Does your organization's formal zero tolerance written policy include procedures designed to prevent acts of sexual misconduct? <input type="checkbox"/> No written policy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If yes, does your policy include a procedure in which you ask employees and volunteers if they have ever been accused of, participated in, or been convicted of sexual misconduct? If yes, please provide copies of all policies or guidelines.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

8. Do your written policies and procedures include these 8 components? (check all that apply)

- Screening – potential employees and volunteers before allowed to work.
- Training – on what constitutes abuse/molestation and how to respond.
- Prevention – listing of detailed ways to minimize occurrences.
- Identification – events, patterns, or trends that can indicate abuse.
- Reporting – how and whom to report concerns or incidents without the fear of retribution (2 people should be identified).
- Investigation – identifying responsibilities of all parties, which include reporting to police as indicated.
- Protection – of victims from harm during investigation.
- Response – analysis of occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.

9. Is the policy consistently enforced, requiring annual review of each employee and/or volunteer, mandating individual signoff that he or she has read the policy, has received appropriate training and agrees to adhere to the policy? Yes  No

10. Have procedures been established to monitor the implementation of the program? Yes  No

11. Are all employees, and those volunteers involved with any activity involving a minor (anyone under the age of 18), required to sign a release form which you keep on file that allows you to request a criminal background check? Yes  No

12. Does your organization conduct nationwide criminal background checks on all employees and volunteers?

All Employees? Yes  No

All Volunteers? Yes  No

13. Does your organization conduct statewide or local criminal or sex offender background checks on all employees and volunteers?

All Employees? Yes  No

All Volunteers? Yes  No

14. Does your organization conduct reference checks\* on all employees and volunteers?

All Employees? Yes  No

All Volunteers? Yes  No

\*The reference check includes contacting, at a minimum, two organizations in which the applicant has previously worked.

15. How long are records retained documenting all screening outlined above? \_\_\_\_\_

16. Are all hiring approval controls verified before employees and volunteers can interact with clients?

All Employees? Yes  No

All Volunteers? Yes  No

17. Do you require that all volunteers be involved with your organization for at least six months before they are allowed in any position involving contact with minors? Yes  No

18. Are criminal background checks run on an ongoing basis for employees, volunteers, and contractors after initial screening? Yes  No

If yes, please describe process: \_\_\_\_\_

**PRIOR INSURANCE COVERAGE AND CLAIMS MADE INFORMATION**

19. Are there any claims or lawsuits pending against your organization (including employees, independent contractors, or volunteers) of which you or any other director, officer or administrator are aware that are not included in the claim information/loss runs provided? Yes  No

• If yes, have all such pending claims been reported to the prior carrier? Yes  No

• If any pending claims have not been reported to the prior carrier, please explain: \_\_\_\_\_

20. Are there any incidents or circumstances known to your organization (you or to any other director or administrator), that have not been reported to the prior carrier, and for which there is reason to believe that such incident or circumstance may give rise to a future claim under the proposed coverage? Yes \* No
21. Has your organization had similar coverage declined, cancelled or non-renewed during the prior five years? (This question is not applicable in Missouri) Yes \* No
- \*For yes answers above, please explain: \_\_\_\_\_

**RESIDENTIAL**  Not Applicable

1. Does organization provide overnight housing of any kind? Yes  No
2. Is property subject to HUD inspection? Yes  No   
If yes, the most recent Real Estate Assessment Center (REAC) inspection report must accompany the application.
3. Are all units equipped with smoke detectors? Yes  No
4. Are all units equipped with carbon monoxide detectors? Yes  No
5. Is smoking prohibited within all buildings and units? Yes  No
6. Are grills or fire pits on any patio or balcony prohibited? Yes  No
7. Are all building(s) five stories or less? Yes  No   
a. Are buildings 100% sprinklered? Yes  No   
b. Do buildings have more than one set of stairs? Yes  No   
c. Are all residents above first floor able to evacuate the building? Yes  No
8. Are individuals convicted of violent or sex crimes prohibited? Yes  No
9. No residents have eloped\* within last 36 months Yes  No   
\*Eloped includes disappeared or gone absent without permission from any facility.
10. Are male and female residents separated? Yes  No
11. Does any facility have a swimming pool? Yes  No
12. What is your staff to resident/client ratio? \_\_\_\_\_
13. Do any of your buildings feature pull cords? Yes  No
14. Do any of your buildings feature aluminum or knob and tube wiring? Yes  No
15. Do any residents receive assistance with Activities of Daily Living Yes  No

If yes, please provide the number of residents/clients by level of functionality below:

Activities of Daily Living (ADL)	Number of Residents/Clients		
	No Physical Assistance Required	Minimal Physical Assistance Required	Cannot Perform without Assistance
Bowel or Bladder Incontinence			
Toileting			
Bathing			
Transferring (In/Out of Bed or Chair)			
Mobility/Walking			
Stairs			
Dressing			
Eating			

What percentage of all residents require minimal assistance? \_\_\_\_\_

What percentage of all residents require full assistance? \_\_\_\_\_

16. Does any facility provide services for:

Type of Clients:			# of Residents/ Clients
Alternative sentencing, incarceration, or involuntary treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Halfway houses or lock-down facilities	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Violent crimes, sex crimes, or offenders who act out sexually	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Homeless or battered families shelter	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Victims of sexual abuse shelter	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Transitional Housing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Medical care (e.g. medical clinic or treatment, skilled nursing)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Methadone treatment, detoxification or needle exchange	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Sober living (post detox)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hospice	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Respite Care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Residential therapeutic treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Assisted living – seniors	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Assisted living – developmentally disabled	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Independent living – seniors	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Independent living – developmentally disabled	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Psychotic disorders (e.g. schizophrenia, schizoaffective, paranoia)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Mood disorders (e.g. bi-polar, mania, manic depressive)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Clients who are severely mentally ill, violent, or suicidal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cognitive disorders (e.g. delirium, dementia, Alzheimer's)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Requiring restraints or restraint techniques	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Have a pyromania or fire starting disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Sexually acting out or pedophilia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Autism	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Eating disorders (e.g. bulimia or anorexia)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Conduct disorders (e.g. impulse control, aggression, vandalism, truancy)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

**PROFESSIONAL LIABILITY**

Not Applicable

1. Are medical services provided? Yes  No   
 Are any non-mental health counseling services provided? Yes  No   
 Are any social work services provided? Yes  No

If yes to any of the above, please complete below:  
 Are any of the following offered or provided?

Infectious/contagious diseases treated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Obstetrical or gynecological services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hospice Services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Medications prescribed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Home health care services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Medications dispensed, injected, or administered?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dental Services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Feed tube maintenance services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Residential skilled nursing services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Methadone treatment, detox, or needle exchange?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Catheterization services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Alternative medical practices provided? (Acupuncture, chiropractic, homeopathy, massage, mental healing, naturopathy, hypnotherapy, etc.)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are any therapy services provided? (Physical, Respiratory, Speech, Vocational, Occupational, etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

If yes to any of the above, please explain: \_\_\_\_\_

2. How many of the following professionals are involved with the organization?

Type	Employee		Volunteer		Contractor	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Medical Director						
Medical Doctor						
Physician Assistant						
Nurse Practitioner						
Nurse Anesthetist						
RN						
LPN						
CNA						
Medical Student						
Nursing Student						
Physical Therapist						
Other Degreed Medical Professional:						
Other Non-Degreed Medical Professional:						
Therapist – Speech						
Therapist – Vocational						
Therapist – Occupational						
Dentist						
Dental Assistant						
Hygienist						
Dental Student						
Other Degreed Dental Professional:						



<i>Continued</i>	Employee		Volunteer		Contractor	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Other Non-Degreed Dental Professional: _____						
Psychiatrist						
Psychiatric Student						
Psychologist						
Psychology Student						
Counselor						
Counseling Student						
Other Counseling Professional: _____						
Social Worker						
Social Work Student						
Other Social Work Professional: _____						
Clergy, Licensed Counselor or Social Worker						
Clergy – Not Licensed						

3. Does the organization currently carry professional liability insurance? Yes  No

Type of Professional Liability	Carrier	Limits	Claims Made (Y or N)/Retro Date

4. Do any employees, volunteers, or contracted staff carry individual professional liability insurance? Yes  No

Does the organization verify the professional liability insurance of individuals? Yes  No

If yes, please list the professionals specifically and limits carried: \_\_\_\_\_  
\_\_\_\_\_

5. Have professional liability negligence allegations been made against:  
a. The organization? Yes  No

b. Any employees, volunteers, or contracted professionals? Yes  No

c. Any service providers of the organization? Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

6. Have any incidents occurred that may result in a professional liability claim being made or suit filed against:

a. The organization? Yes  No

b. Any employees, volunteers, or contracted professionals? Yes  No

c. Any service providers of the organization? Yes  No

If yes, please describe: \_\_\_\_\_

7. Does your organization conduct checks on education, licensing, and professional credentials on all employees and volunteers?  
 Employees? Yes  No   
 Volunteers? Yes  No

8. Does organization maintain records of professional licenses for:  
 a. Employees? Yes  No   
 b. Volunteers? Yes  No   
 c. Contracted professionals? Yes  No

9. Is the organization accredited by a third party? Yes  No   
 If yes, list accreditations and accrediting bodies: \_\_\_\_\_

10. Does organization provide referrals to other organizations? Yes  No

Type of Referral	Number of Annual Referrals	Type of Referral	Number of Annual Referrals
Adoption Placements		In-Home Assistance	
Foster Placements		Group Home	
Medical Care		Residential Placement	
Mental Health Care		Day Care or Latchkey	
Counseling		Other: _____	
Social Work		Other: _____	

Are written contracts required with service providers? Yes  No   
 Is organization held harmless by contract with service provider? Yes  No   
 Are service providers licensed within state of operation? Yes  No   
 If no, please explain: \_\_\_\_\_  
 Does organization verify insurance for service providers? Yes  No   
 Is organization an additional insured on service provider policy? Yes  No

Auto		<input type="checkbox"/> Not Applicable	
1.	Does your organization own any vehicles used for business purposes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Does your organization purchase a business owned auto liability insurance policy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Are all owned vehicles titled to the organization? If no, explain including the name(s) of the titled owner: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Do any vehicles owned, leased or rented:		
a.	Have any wheelchair lifts? If yes, do vehicles equipped for wheelchairs have tie down belts to stabilize the wheelchair and passenger?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b.	Seat more than 15 people? If yes, do you require seat belts to be worn by all occupants?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c.	Used to transport individual or property for a fee?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d.	Used to provide transportation to clients or public?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e.	Used to deliver meals, food or other products?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f.	Used to deliver services to clients, volunteers or the public?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g.	Require a commercial driver's license (CDL)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<p><b>h.</b> Tractor-trailers or have refrigeration units? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>                  If yes to any items above, please describe: _____</p>
<p><b>5.</b> If organization has fleet (five or more vehicles), please submit copies of vehicle safety and fleet maintenance programs.</p>
<p><b>6.</b> Do volunteers operate any owned, leased, or rented vehicles? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>                  If yes, please describe: _____</p>
<p><b>7.</b> Does your organization obtain a copy of driver's licenses for all employees, independent contractors, and volunteers and confirm they are valid? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>8.</b> Does your organization run Motor Vehicle Reports prior to hiring an individual whose job duties include operating a company vehicle for the organization? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>9.</b> Does your organization check the Motor Vehicle Reports on an annual basis for all employees, independent contractors and volunteers for all those that transport clients? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>                  If yes, do you validate that all drivers meet the following guidelines:</p>
<p><b>a.</b> Have no alcohol or drug-related violations within the past three years? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>b.</b> Have none of the following violations within the past three years:                  Careless/reckless driving, speed in excess of 20 mph over the limit or driver's license suspended, revoked, canceled, or barred? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>10.</b> Are vehicles or motorized conveyances accepted as donations? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>a.</b> Are donated vehicles handled/brokered by: <input type="checkbox"/> Third Party <input type="checkbox"/> Organization</p>
<p><b>b.</b> Are donated vehicles sold in "as is" condition to a third party? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>c.</b> Are donated vehicles used for the organization's operations? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>11.</b> Does your organization allow employees, independent contractors, or volunteers use of their personal vehicles on behalf of the organization? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>12.</b> How many employees, independent contractors or volunteers use their own vehicle for company business?                  Employees: _____ Independent Contractors: _____ Volunteers _____</p>
<p><b>13.</b> Do any of your organization's employees, independent contractors or volunteers drive client owned vehicles during the course of your business? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>14.</b> Do employees, independent contractors or volunteers transport clients using their personal vehicles? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>15.</b> Are drivers of personal vehicles on behalf of the organization required to be properly licensed to operate vehicles driven? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>16.</b> Are drivers of personal vehicles on behalf of the organization required to annually provide proof of personal auto insurance? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>17.</b> Does your organization require each employee, independent contractor and volunteer to provide evidence of insurance with personal auto limits of at least \$100,000/\$300,000 or \$300,000 CSL limits? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>18.</b> Does your organization run Motor Vehicle Reports prior to hiring an individual whose job duties include operating a personal vehicle for the organization? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>19.</b> Do any personal vehicles used on behalf of the organization:</p>
<p><b>a.</b> Have any wheelchair lifts? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p>If yes, do vehicles equipped for wheelchairs have tie down belts to stabilize the wheelchair and passenger? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>b.</b> Seat more than 15 people? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p>If yes, do you require seat belts to be worn by all occupants? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>c.</b> Used to transport individual or property for a fee? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>d.</b> Used to provide transportation to clients or public? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>
<p><b>e.</b> Used to deliver meals, food or other products? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p>

<b>f.</b>	Used to deliver services to clients, volunteers or the public?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>g.</b>	Require a commercial driver's license (CDL)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>h.</b>	Tractor-trailers or have refrigeration units?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If yes to any items above, please describe: _____		

ADVERTISING & MEDIA EXPOSURE		<input type="checkbox"/> Not Applicable	
<b>1.</b>	Does organization currently have media, advertising, broadcasting, or publisher's liability insurance? If yes, please describe: _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.</b>	Does organization create its own advertising/marketing materials? If no, please list who creates these materials: _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.</b>	Does organization have printed marketing materials? (Brochures, pamphlets, annual report, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>4.</b>	Do marketing materials contain pictures taken by organization? If yes, are releases obtained from individuals in photos?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>5.</b>	Does organization have a website? If yes, please provide website address and list who hosts and maintains website content: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>6.</b>	Does organization air TV, radio, or internet broadcasts/PSA's, etc.? If yes, please describe including how often broadcasted: _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>7.</b>	Does organization publish any materials? Does organization sell any materials created or published? If yes, please list, describe, and provide annual sales receipts (if applicable) _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>8.</b>	Is outside legal counsel used to review all materials? If no, please describe how materials are reviewed before publication, broadcast or sold: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**SALES OR DISTRIBUTION ACTIVITIES**

**Not Applicable**

- 1. Does organization sell, donate, or distribute food or merchandise? Yes  No   
If yes, please describe operations and the food or merchandise items: \_\_\_\_\_
- 2. Inventory or merchandise is delivered to organization's location(s)? Yes  No   
If yes, please describe who delivers and modes of transportation: \_\_\_\_\_
- 3. Inventory or merchandise is picked up by the organization? Yes  No   
If yes, please describe who picks up goods and mode of transportation: \_\_\_\_\_
- 4. Is racking above one level utilized to store inventory? Yes  No   
a. Describe and provide a picture of inventory racking: \_\_\_\_\_  
b. Are shoppers allowed to retrieve merchandise from racking? Yes  No
- 5. Are forklifts used in the operations? Yes  No   
a. Are forklift operators certified to operate forklifts? Yes  No   
b. Do all forklifts have back-up alarms? Yes  No   
c. Does organization have written procedures for forklift use? Yes  No   
d. Are forklifts used while customers are shopping? Yes  No
- 6. Does organization sell, donate, or distribute directly to individuals or organizations? Yes  No

	Distributed to Individuals	Distributed to Organizations
Gross annual sales revenues		
Value of items annually distributed		
Weight (pounds) of items annually distributed		
Maximum value of any individual item		

- 7. Are any warranties offered or provided? Yes  No   
If yes, please describe: \_\_\_\_\_
- 8. Are any items or packages:
  - a. Repackaged? Yes  No
  - b. Repaired? Yes  No
  - c. Refurbished? Yes  No
  - d. Modified? Yes  No
  - e. Relabeled or labels modified? Yes  No
  - f. Labels removed? Yes  No
 If yes, please describe: \_\_\_\_\_

**SHELTERED WORKSHOPS & VOCATIONAL TRAINING**

Not Applicable

- 1. Does organization provide vocational training? Yes  No
- 2. Does organization provide a sheltered workshop? Yes  No
- 3. Does organization pay clients lower than the minimum wage? Yes  No   
If yes, please explain wage level paid to clients: \_\_\_\_\_
- 4. Are clients covered under organization's workers' compensation policy? Yes  No   
If no, please explain: \_\_\_\_\_

	Number	Payroll
Total Clients per Day		
Physically Disabled Clients		
Developmentally Disabled Clients		
Job Coaches		
Trainers		
Supervisors		

**Clients perform or are training in the following activities:**

<input type="checkbox"/> Appliance Repair	<input type="checkbox"/> Heat Sealing/Shrink Wrapping	<input type="checkbox"/> Packaging
<input type="checkbox"/> Assembly	<input type="checkbox"/> Janitorial	<input type="checkbox"/> Painting
<input type="checkbox"/> Bicycle Repair	<input type="checkbox"/> Landscaping	<input type="checkbox"/> Recycling
<input type="checkbox"/> Cooking	<input type="checkbox"/> Laundry/Dry Cleaning	<input type="checkbox"/> Screen Printing
<input type="checkbox"/> Construction	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Sewing
<input type="checkbox"/> Electrical	<input type="checkbox"/> Office Work	<input type="checkbox"/> Welding

**Use or operation of:**

<input type="checkbox"/> Baling Machinery	<input type="checkbox"/> Metal Shearing Machinery	<input type="checkbox"/> Press Brakes
<input type="checkbox"/> Conveyor Systems	<input type="checkbox"/> Power Tools	<input type="checkbox"/> Scaffolding
<input type="checkbox"/> Corrosive Chemicals/Flammables	<input type="checkbox"/> Presses	<input type="checkbox"/> Other _____

If any of the above operations or activities, or others not listed, please describe: \_\_\_\_\_

- 5. If assembly, manufacturing, or packaging performed:
  - a. Involves auto, truck, aircraft, or aerospace industry? If yes, contact your underwriter before submitting. Yes  No
  - b. Are written controls in place? Yes  No
  - c. Do contracts contain hold harmless clauses? Yes  No
  - d. Are product components stored by organization? Yes  No
  - e. Are completed products stored by organization? Yes  No
- 6. Total annual sales from workshop: \_\_\_\_\_
- 7. Does organization employ a safety coordinator or manager? Yes  No
- 8. Does organization have a formal orientation program? Yes  No   
If yes, please describe: \_\_\_\_\_



**INSURANCE FRAUD WARNING:**

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.

**Applicable in AL, AR, DC, LA, MD, NM, RI and WV:** Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof. \*Applies in MD only.

**Applicable in CO:** 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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Applicable in FL and OK:** 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).\* Applies in FL only.

**Applicable in KS:** 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 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 the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**Applicable in KY, NY, OH and PA:** 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 material 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \* Applies in NY only.

**Applicable in ME, TN, VA and WA:** 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 and denial of insurance benefits. \*Applies in ME only.

**Applicable in NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**ACKNOWLEDGEMENT AND SIGNATURES:**

The undersigned is an authorized representative of the applicant and represents that reasonable enquiry has been made to obtain the answers to questions on this application. He/she represents that the answers are true, correct and complete to the best of his/her knowledge.

**INSURED MUST SIGN THIS APPLICATION IN ORDER FOR IT TO BE VALID**

Authorized Insured Representative:		Date:	
Print Name:		Title or Position:	
Agent No.:	Agency:	Producer's Signature:	License No.: