McKee Risk Management, Inc.

MENTAL HEALTH SERVICES QUESTIONNAIRE

The following questionnaire must be signed and submitted for underwriting approval prior to binding coverage.

Refer to Part D. for Unacceptable Classes

PART A: GENERAL INFORMATION

1.	Insured Name:	
2.	Effective Date:	
3.	Number of years in operation: Under Present Management: ☐ Non-Profit ☐ For-Profit	
4.	Basic scope of operations:	
5.	Does the applicant have a web site? (If yes, please provide URL): Is the site managed by the applicant or a third party?	☐ Yes ☐ No ☐ Yes ☐ No
6.	Annual operating budget: Annual payroll: Primary funding: ☐ Federal ☐ State ☐ County ☐ Other: If Yes, explain:	
7.	List all accreditations:	
8.	List all association memberships or affiliations:	
9.	Has your license ever been suspended or revoked? If Yes, explain:	☐ Yes ☐ No
10.	Do you provide any child foster care?	☐ Yes ☐ No

PART B: MENTAL HEALTH PROGRAMS

		No. of Beds	
1.	Residential Services for Adults:		
	Short Term Treatment		☐ Yes ☐ No
	Long Term Treatment		☐ Yes ☐ No
	Residential Service (Age 12 to 18):		
	Short Term Treatment		☐ Yes ☐ No
	Long Term Treatment		☐ Yes ☐ No
2.	Outpatient Counseling?		☐ Yes ☐ No
	Suicide Hot Line Services?		☐ Yes ☐ No
	Telephone referral services?		☐ Yes ☐ No
3.	Crisis intervention – Voluntary inpatient?		☐ Yes ☐ No

PART C: MENTAL HEALTH PROGRAMS (ACCEPTABLE CLASSES)

1.	Services for depression	☐ Yes ☐ No
2.	Services for attention deficit disorder	☐ Yes ☐ No
3.	Services for manic disorder	☐ Yes ☐ No
4.	Services for anxiety disorder	☐ Yes ☐ No
5.	Services for personality disorder	☐ Yes ☐ No
6.	Services for schizophrenia	☐ Yes ☐ No
7.	Services for paranoia	☐ Yes ☐ No
8.	Services for rape counseling	☐ Yes ☐ No
9.	Services for behavioral disorder	☐ Yes ☐ No
10.	Services for eating disorders	☐ Yes ☐ No
11.	Services for family counseling	☐ Yes ☐ No
12.	Services for victim counseling	☐ Yes ☐ No
13.	Services for bi-polar	☐ Yes ☐ No

PART D: MENTAL HEALTH PROGRAMS (NOT ACCEPTABLE)

1.	Residential Services for children under the age of 12	☐ Yes ☐ No
2.	Services for violent criminal offenders	☐ Yes ☐ No
3.	Services for pedophile/sexual aggression treatment	☐ Yes ☐ No
4.	Services for fire starter treatment	☐ Yes ☐ No
5.	Services for court-designated criminally insane	☐ Yes ☐ No
6.	Services for alternative sentencing, incarceration or lock-down programs	☐ Yes ☐ No
7.	Services for foster care	☐ Yes ☐ No
8.	Home health care	☐ Yes ☐ No
9.	Services for court-appointed juvenile justice program	☐ Yes ☐ No
10.	Designated licensed mental heath institution/hospital	☐ Yes ☐ No

PART E: MANAGEMENT PRACTICES AND PREMISES / LIFE SAFETY

1.	If the building you occupy was built prior to 1978, has it been inspected for lead paint? If No, what is the plan for abatement?	☐ Yes ☐ No
2.	Do you have any plans for renovations or new construction? If Yes, explain:	☐ Yes ☐ No
3.	Do you have any vacant buildings now? Describe any planned for the future:	☐ Yes ☐ No
4.	Are any non-ambulatory patients above the first floor?	☐ Yes ☐ No
5.	Number of fire extinguishers on premises: How often are they serviced?	
6.	Are all exits clearly marked in the event of a fire?	☐ Yes ☐ No
7.	Do you have a written emergency evacuation plan? How often are drills held?	☐ Yes ☐ No
8.	Describe housekeeping and maintenance practices:	
9.	Describe the parking facilities: Are they well lit?	☐ Yes ☐ No
10.	Is the hot water heater set to a maximum temperature of 120 degrees?	☐ Yes ☐ No
11.	Has your facility been inspected by an insurance company or independent inspection firm? If Yes, by whom? List any deficiencies and corrective actions in the past three years:	☐ Yes ☐ No
12.	Do you have sign in/sign out procedures for: ☐ Staff ☐ Clients/Residents ☐ Visitors	
13.	Is staff required to report to the administrator all incidences that may result in a claim?	☐ Yes ☐ No
14.	Are written records of all incidences kept by the administrator?	☐ Yes ☐ No
15.	Do you have a written and enforced no smoking policy? Are "no smoking" signs posted and enforced in all areas not designated for smoking?	☐ Yes ☐ No ☐ Yes ☐ No
16.	Do you have AED(s)? Are staff members trained to use it?	☐ Yes ☐ No ☐ Yes ☐ No

PART F: PROFESSIONAL LIABILITY

1.	Does your pre-employment background include: a. Professional references? b. Fingerprint/FBI check? c. State-level criminal background check? d. Education Verification?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
2.	While in your employment or under contract, has any person performing professional services ever been reprimanded, suspended or disciplined by any agency or governmental entity?	☐ Yes ☐ No
3.	Do you maintain a medication log for all dispensed medications?	☐ Yes ☐ No
4.	What is the staff turnover rate for the last 12 months?	
5.	Do you contract with individuals to perform professional services on behalf of your organization?	☐ Yes ☐ No
6.	Do you obtain certificates of insurance, as evidence of medical malpractice coverage carried, for employed/contracted/volunteer medical doctors? a. What limits do you require that they carry? b. Do you confirm that coverage extends to services that MDs perform for/on behalf of your organization?	☐ Yes ☐ No ☐ Yes ☐ No

PART F: PROFESSIONAL LIABILITY (continued)

7.	Does your current insurance program provide professional liability coverage? If Yes: ☐ Occurrence ☐ Claims-made Limits: Retroactive Date: Effective dates: Carrier:	☐ Yes ☐ No

8. Physicians and Psychiatrists (use additional paper as necessary):

Name	Dr.	Dr.	Dr.
Position			
Degree			
Years in Practice			
License #			
Hours per week for insured			
Employed, Volunteer or Contracted?			
Duties for insured			
Any claims in past 5 years?			

9. Staff:

POSITION	EMPLOYEES		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Administrator								
Counselor								
Dentist/Dental Hygienist								
Home Health Aide								
Nurse Practitioner								
Nurse – LPN								
Nurse – RN								
Nutritionist/Dietician								
Optometrist								
Pharmacist								
Physician Assistant								
Physician								
Psychiatrist								
Psychologist								
Social Worker – Bachelors (BSW)								
Social Worker – Masters (MSW)								
Teacher/Tutor/Aide								
Therapists – Occupational								
Other Positions								
Total:	0	0	0	0	0	0	0	0

10. Describe procedures in place with staff changes shifts:

11. Do you employ physical restraints? ☐ Yes ☐ No

If yes, what is your physical restraint policy?

Are two people present while it is implemented? ☐ Yes ☐ No

Are your employees trained? ☐ Yes ☐ No

What training methods have you implemented?

12. What is the staff to client ratio for each program?

13. Are psychologists permitted/licensed to administer medications in your state? ☐ Yes ☐ No

PART G: ABUSE AND MOLESTATION

1.	Total number of clients served by Insured: Residential: Non-Residential:	
2.	Does your current insurance program include Abuse and Molestation coverage? If Yes, what are the limits? ☐ Occurrence ☐ Claims-Made	☐ Yes ☐ No
3.	Does your employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses?	☐ Yes ☐ No
4.	Do you have a written crisis plan in place if you have an incident of abuse?	☐ Yes ☐ No
5.	Are there written complaint procedures and are they displayed prominently? If Yes, explain:	☐ Yes ☐ No
6.	Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises, in order to mitigate abusive relationships?	☐ 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.	Have any incidents resulted in an allegation of sexual abuse? Was the case settled? Was the case taken to trial? Amount paid for damages to the victim: $ Does Insured run criminal background checks? Employees: Volunteers:	☐Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
10.	Any one-on-one mentoring conducted off-premises?	☐ Yes ☐ No
11.	Are criminal investigation/background checks conducted on all staff, including the owner/director and volunteers before hiring? Staff: Owner/Executive Director: Volunteers: **Elaborate:**	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
12.	Do any of your current employees, staff, volunteers, principals, board members, officers or directors have a history of arrests, charges or convictions for a crime that includes sex-related or child abuse offenses? If Yes, explain:	☐ Yes ☐ No
13.	After how many years are background checks obtained for every director, employee and volunteer?	
14.	Does orientation include discussion of the following: Client abuse Sexual abuse How to recognize the signs? What to do if a client reports someone molested her/him?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
15.	Do you require mandatory training for all staff on client abuse each year?	☐ Yes ☐ No
16.	Is there one person that employees/volunteers can report concerns confidentially?	☐ Yes ☐ No
17.	Are all alleged abuse incidents investigated promptly by an objective party? **Elaborate:**	☐ Yes ☐ No

PART H: RESIDENTIAL ☐ **N/A**

1.	Annual number of clients by age group: Less than 18: 18-34: 35-65: Over 65:	
2.	What security measures are in place?	
3.	Specify number of Males: Females:	
4.	Are residents separated? How are they separated?	☐ Yes ☐ No
5.	Total number of rooms: Number of bedrooms:	
6.	What was the date of the last inspection by a licensing agency? Were there any violations or deficiencies noted? If yes, explain:	 ☐ Yes ☐ No
7.	Does a physician screen clients prior to admission?	☐ Yes ☐ No
8.	Do you require signed release forms for the release of records to other individuals or institutions?	☐ Yes ☐ No
9.	Are residents primarily responsible for their own basic personal care including bathing, dressing, eating, and restroom aid?	☐ Yes ☐ No

PART H: RESIDENTIAL (continued) ☐ **N/A**

10.	Is the staff trained in non-violent crisis intervention? If Yes, which protocol?	☐ Yes ☐ No
11.	What is the ratio of residents to staff? Day: Night:	
12.	What procedures are in place for clients who are permitted to leave the premises without supervision?	
13.	How many visits per month are made by a caseworker to a resident?	
14.	How often are the rooms inspected? Who inspects the rooms? Do you have written procedures? Do you keep a checklist?	 ☐ Yes ☐ No ☐ Yes ☐ No
15.	How often are bed checks done? ☐ Random ☐ Scheduled If scheduled, how often are they done?	
16.	Are there security cameras monitoring operations?	☐ Yes ☐ No
17.	Are residents' doors ever locked from the outside?	☐ Yes ☐ No
18.	Are residents allowed to cook their own meals? If Yes, in ☐ Private or ☐ Common cooking areas?	☐ Yes ☐ No

PART I: OUTPATIENT FACILITIES ☐ **N/A**

TYPE OF SERVICE	# VISITS	TYPE OF SERVICE	# VISITS

1.	Annual number of clients by age group: Less than 18: 18-34: 35-65: Over 65:	
2.	Annual number of clients by category: Emotional/Behavioral: Drug/Alcohol: Physical/Intellectual Disabilities: Mental Health:	
3.	Explain screening procedures for clients:	
4.	Do you operate a clinic? If Yes, annual number of calls received: What types of calls? ☐ Drug/Alcohol ☐ Child/Spousal Abuse ☐ Other What are the hours of operation for the hotline? Is training provided? Do volunteers answer calls?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
5.	Do you provide respite care programs? If Yes, maximum amount of consecutive days: Do you ☐ take all ages or ☐ do you specialize? Explain: Can parents/caretakers meet and interview the people who will be providing the care? Do you maintain records of services?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
6.	Do you provide any program for sexual offenders? If yes, number of clients and describe typical offenses:	☐ Yes ☐ No
7.	Do you provide any program for juvenile delinquents? If yes, number of clients and describe typical offenses:	☐ Yes ☐ No
8.	Do you provide any services for ex-offenders or incarcerated individuals? If yes, number of clients and describe typical offenses:	☐ Yes ☐ No
9.	Do you operate a meal delivery service? Do you charge a fee? If Yes, total revenue: $	☐ Yes ☐ No ☐ Yes ☐ No

PART J: THERAPEUTIC HORSEBACK RIDING ☐ **N/A**

1.	Are liability waivers signed by all parents/guardians?	☐ Yes ☐ No
2.	Do you or your instructors have regional or national riding certificates?	☐ Yes ☐ No
3.	Do you follow North American Riding for the Handicapped Association standards?	☐ Yes ☐ No
4.	Do you fasten a child to any part of the saddle?	☐ Yes ☐ No
5.	Are safety helmets mandatory?	☐ Yes ☐ No
6.	Do you provide transportation to and from the facility?	☐ Yes ☐ No
7.	Total annual lessons: Average size of groups:	
8.	What is the experience of the staff?	
9.	What is the ratio of riders to counselors? Minimum age of riders:	

PART K: SPECIAL EVENTS/FUNDRAISING ☐ **N/A**

	QUESTIONS	EVENT #1	EVENT #2	EVENT #3
1.	Describe the type of event:			
2.	Total anticipated revenue:			
3.	Location of event:			
4.	Anticipated dates of the event:			
5.	Activities involved:			
6.	Number of participants.			
7.	Will alcohol be served? If yes,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	a. Who will supply the alcohol?			
	b. Are bartenders hired by you?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Or establishment where event is held?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	c. If hired by you, have the bartenders been trained in TIPS?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	d. What procedures are in place to limit drinking?			
	– Tickets provided?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	– Cash bar?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	– Open bar?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	e. Is a Liquor Liability policy in place covering this event?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	f. Liquor License required?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PART L: AUTOMOBILE ☐ **N/A**

1.	Are all vehicles insured on the schedule titled to the Named Insured? If no, explain:	☐ Yes ☐ No
2.	What is the primary use of vehicles: transporting clients daily, running errands daily, picking up kids etc.?	
3.	Do you rent vehicles for revenue – e.g parties, weddings, etc.?	☐ Yes ☐ No
4.	Are keys locked and secured away from clients when not in use?	☐ Yes ☐ No
5.	Are vehicles with 8 or more seating capacity equipped with an audible backup warning device?	☐ Yes ☐ No
6.	If you operate 15-passenger vans, do you routinely check for proper tire inflation? Explain:	☐ Yes ☐ No
7.	Are vehicles checked after passengers disembark to make sure no one is left behind?	☐ Yes ☐ No
8.	Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger?	☐ Yes ☐ No
9.	Do you require seat belts to be worn by all occupants?	☐ Yes ☐ No
10.	Explain your vehicle maintenance program:	
11.	Do you accept donated vehicles? If yes, when and how does title transfer to you? Explain: Do you repair any vehicles? If Yes, describe the types of repairs: If you sell the donated vehicles yourself, do you sell them “as is” with no guarantees? If no, explain:	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

PART M: HIRED AND NONOWNED EXPOSURE ☐ **N/A**

1.	Do you hire vehicles? If Yes, what types of vehicles do you hire?	☐ Yes ☐ No
	Do you obtain certificates of insurance? What minimum limits do you require?	☐ Yes ☐ No
2.	Do you hire from a transportation company? If Yes, with drivers?	☐ Yes ☐ No ☐ Yes ☐ No
3.	Total number of hired vehicles annually: Annual cost of hire:	
4.	Do employees/volunteers transport children in their own vehicles? If Yes, how often?	☐ Yes ☐ No
5.	How many drive personal vehicles for business use regularly? F/T: P/T: Vol: How many drive personal vehicles for business use occasionally? F/T: P/T: Vol:	
	Do you obtain proof of insurance for employees/volunteers who use their own autos with minimum limits of $100,000? If no, are you willing to implement procedures? Do you update your records at least annually?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

PART N: DRIVER INFORMATION ☐ **N/A**

1.	Do you obtain a written authorization to release driver information from all of your staff upon hiring? Do you obtain MVRs on all drivers? If Yes, how often?	☐ Yes ☐ No ☐ Yes ☐ No
2.	Explain procedures for dealing with driver accidents or violations:	
3.	Are all drivers at least 21 years of age? How many drivers are over age 70?	☐ Yes ☐ No
4.	Have drivers attended a class in defensive driving? Explain:	☐ Yes ☐ No
5.	Is training provided for new employees/volunteers prior to their transporting clients?	☐ Yes ☐ No
6.	Does anyone besides employees or volunteers drive your vehicles? If Yes, explain:	☐ Yes ☐ No
7.	Is personal use of Insured’s vehicles permitted? Explain:	☐ Yes ☐ No

PART O: SUBSTANCE ABUSE PROGRAMS ☐ N/A

1.	Is treatment ☐ individual or ☐ group? Number of group sessions annually: Number of individual sessions annually:	
2.	Do you provide a methadone maintenance program? If yes, where is the methadone stored? Number of methadone-only clients annually: Number of clients with take home privileges: Describe measures to guard against the diversion of methadone by employees and/or clients:	☐ Yes ☐ No
3.	Do you operate a detoxification unit? If Yes, ☐ Medical ☐ Other If Medical, do you accept clients with a history of delirium tremens (DTs) or seizures? If clients are experiencing DTs or seizures, do you ☐ treat them or ☐ refer them to a hospital?	☐ Yes ☐ No ☐ Yes ☐ No
4.	Do you operate drug/alcohol rehabilitation? If Yes, are these for adults only? Are facilities single sex?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
5.	Describe intake assessment procedures:	
6.	Describe procedures for letting clients in after a home visit:	
7.	Do you check if client is under the influence?	☐ Yes ☐ No
8.	Do you check if clients have possession of drugs?	☐ Yes ☐ No
9.	Are visitors screened for drug possession?	☐ Yes ☐ No

PART P: CAMPS ☐ N/A

1.	Is written permission/waiver of liability obtained from every child's parent or guardian?					☐ Yes	☐ No
2.	Does the camp provide overnight services? If Yes, what is the average length of stay?					☐ Yes	☐ No
3.	Total number of days in operation annually: Number of children at each camp:						
4.	Number of staff members at each camp:						
5.	What are the qualifications of staff working with adolescents?						
6.	Are sleeping quarters co-ed?	☐ Yes	☐ No	☐ N/A	Are restrooms/showers co-ed?	☐ Yes	☐ No
7.	If well water, how often is it tested?						
8.	Indicate and describe if any of the following exposures exist in the camp operations: ☐ Obstacle course ☐ Motor boats ☐ Archery ☐ Jet skis ☐ Water skiing ☐ Pools ☐ Guns ☐ Rock climbing ☐ Diving boards ☐ Horses ☐ Lakes ☐ Other:						

PART Q: SHELTERED WORKSHOP ☐ N/A

1.	Do the jobs involve:	Power tool/Power equipment	☐ Yes ☐ No
		Plastic molding?	☐ Yes ☐ No
		Woodworking/Pallet manufacturing?	☐ Yes ☐ No
		Spray painting?	☐ Yes ☐ No
		Electrical wiring?	☐ Yes ☐ No
		Welding?	☐ Yes ☐ No
		Heat sealing?	☐ Yes ☐ No
		Chemicals?	☐ Yes ☐ No
		Janitorial Services? If yes, provide annual payroll $	☐ Yes ☐ No
		Landscaping/Lawn care? If yes, provide annual payroll $	☐ Yes ☐ No
	Other types of jobs provided (be specific):		
2.	Do you contract with manufacturers for particular projects? If yes, do your contracts include a hold-harmless clause favoring the workshop? Do any of your contracts require you to indemnify the manufacturers? If yes, explain:		☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
3.	Are you named as an Additional Insured on the manufacturer's policy?		☐ Yes ☐ No
4.	Are clients covered by worker's compensation insurance?		☐ Yes ☐ No
5.	Average number of clients daily:		
6.	Staff to client ratio:		
7.	Do staff make follow up visits to clients placed in outside employment?		☐ Yes ☐ No

PART R: COOKING FACILITIES ☐ **N/A**

1.	The cooking equipment is: ☐ Electric ☐ Gas ☐ Propane ☐ Other	
2.	The cooking equipment is located in: ☐ One common area ☐ Each floor ☐ Individual Rooms ☐ Other Total number of cooking areas:	
3.	Who has access to the cooking area? ☐ Staff ☐ Clients/Residents ☐ Volunteers ☐ Visitors/Public	
4.	For whom is food prepared? ☐ Staff ☐ Clients/Residents ☐ Volunteers ☐ Visitors/Public	
5.	The equipment type is: ☐ Residential ☐ Commercial If commercial, complete the following section: a. Describe equipment (e.g., grills, broilers, fryers, etc) and number of each: b. Cooking equipment is equipped with ☐ Hoods ☐ Ducts ☐ Exhaust Fans ☐ No Protection ☐ Automatic Fire Suppression Systems ☐ Automatic Fuel Shutoff Controls ☐ Other c. Is there a cleaning maintenance contract for the fire extinguishing system? If yes, what is the frequency of the cleaning? What is the name of the maintenance company? Is the system UL 300/NFPA compliant? d. Are the duct, hood, and filter cleaned regularly?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
6.	Do any staff members supervise the cooking area?	☐ Yes ☐ No
7.	Are there fire extinguishers in the cooking area(s)?	☐ Yes ☐ No

Please attach the following:

☐ ACORD applications, including Crime and Umbrella
☐ Statement of values, if applicable
☐ Schedule of vehicles
☐ Drivers list with license numbers and dates of birth
☐ Loss runs for current year and 3 prior years
☐ Brochure and/or newsletter
☐ Financial statement if for-profit
☐ Photographs – residential locations

NOTICE TO APPLICANT – PLEASE READ CAREFULLY

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED WARRANTS THAT TO THE BEST OF HIS/HER KNOWLEDGE THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO ISSUE, OR THE APPLICANT TO PURCHASE, ANY INSURANCE POLICY.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER. THIS APPLICATION WILL BECOME A PART OF SUCH POLICY, IF ISSUED. THE INSURER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING THIS POLICY. IN THE EVENT THAT THE APPLICATION CONTAINS ANY MISREPRESENTATION OR MISSTATEMENT OF A MATERIAL FACT, THIS POLICY SHALL NOT AFFORD COVERAGE TO ANY INSURED WHO KNEW OF SUCH MISREPRESENTATION OR MISSTATEMENT.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT MUST PROVIDE WRITTEN NOTIFICATION TO THE INSURER, WHO MAY MODIFY OR WITHDRAW THE QUOTATION.

THE UNDERSIGNED FURTHER AGREES TO AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION IN THIS APPLICATION TO A LOSS CONTROL PROVIDER THAT PROVIDES LOSS CONTROL SERVICES TO THE INSURER AND TO COMPLY WITH THE TERMS AND CONDITIONS OF THOSE LOSS CONTROL SERVICES.

THE UNDERSIGNED DECLARES THAT THE INDIVIDUALS AND ORGANIZATIONS PROPOSED FOR THIS INSURANCE HAVE BEEN NOTIFIED THAT:

A. THIS POLICY APPLIES ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE; AND

B. THE LIMIT OF LIABILITY IS REDUCED BY AMOUNTS INCURRED AS DAMAGES AND SUCH EXPENSES WILL BE SUBJECT TO THE DEDUCTIBLE AND/OR CO-PAYMENT AMOUNT.

FRAUD STATEMENT

Your completion of this Supplemental Application in conjunction with the Commercial Insurance Application constitutes an affirmation by you that you are an authorized representative of the applicant, that a reasonable inquiry has been made to obtain the answers to the questions on this Supplemental Application, and that the answers provided in this Supplemental Application are true, correct and complete to the best of your knowledge. Your completion of this Supplemental Application also constitutes an affirmation by you that you are aware of the insurance fraud warnings set forth at length in the Commercial Insurance Application.

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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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 settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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, or 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT TO TENNESSEE 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.

FRAUD STATEMENT 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.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, or VT; in DC, LA, ME, TN, and VA, insurance benefits may also be denied.)

I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE INFORMATION PROVIDED IS TRUE AND CORRECT AND THAT NO INFORMATION WHICH MATERIALLY AFFECTS THIS INSURANCE HAS BEEN WITHHELD. THE INSURER IS AUTHORIZED (BUT NOT OBLIGATED) TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. ACCEPTING THIS APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE INSURANCE.

APPLICANT'S SIGNATURE: _____ **DATE:** _____

AGENT'S SIGNATURE: _____ **DATE:** _____