|  |  |
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| logo.jpg Insight. Experience. Commitment. | AIS Friendship Centre and Wellness Centre Application  |

Table of Contents

Introduction / Executive Summary 3

Property Section 4

Property Technical 8

Boiler and Machinery 12

Commercial General Liability 15

Commercial General Liability Questionnaire18

Umbrella Liability 41

Crime 43

Auto Fleet information 45

Garage Automobile Section 50

Criminal Legal Defence 51

Accidental Death & Dismemberment 52

Ventures Schedule of Values 53

Ventures Auto Schedule 54

Declaration 55

Introduction / Executive Summary

|  |
| --- |
|       |

Property Section

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |

|  |  |
| --- | --- |
| Name of Insured |       |

|  |  |
| --- | --- |
| **Type** | **Information / Description** |
| **Location** |       |
| **Construction** |       |
| **Building** |       |
| **Equipment** |       |
| **Stock** |       |
| **Business Interior** |       |
| **Total** |       |

|  |
| --- |
| **Property / Risk Insured** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Property of Every Description anywhere in Canada or the United States including in transit |       | [ ]  Yes [ ]  No |
| Business Interruption – Profits |       | [ ]  Yes [ ]  No |
| Indemnity Period – 12 months |       | [ ]  Yes [ ]  No |
| Ordinary Payroll –       days |       | [ ]  Yes [ ]  No |
| Business Interruption – Gross Earnings |       | [ ]  Yes [ ]  No |
| Coinsurance 50% 80% |       | [ ]  Yes [ ]  No |
| Ordinary Payroll –       days |       | [ ]  Yes [ ]  No |
| Gross Rentals |       | [ ]  Yes [ ]  No |
| Extra Expense |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Perils Insured** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| **Basis of Loss Settlement** |
| Buildings and Equipment – Replacement Cost |       | [ ]  Yes [ ]  No |
| Stock – Selling Price |       | [ ]  Yes [ ]  No |
| Bylaws coverage applicable to Buildings and Equipment |       | [ ]  Yes [ ]  No |
| Functional Replacement Cost on EDP Equipment and Media |       | [ ]  Yes [ ]  No |
| Additional Time required for rebuilding |       | [ ]  Yes [ ]  No |
| All Risks of Physical Loss or Damage including Earthquake, Flood and Sewer Backup |       | [ ]  Yes [ ]  No |

**Limits of Liability**

|  |  |
| --- | --- |
| Any One Occurrence |       |
|  |  |
| Annual Aggregate – Earthquake |       |
|  |  |
| Annual Aggregate – Flood |       |

**Sublimit**

Automatic Coverage – Newly Acquired Locations

|  |  |
| --- | --- |
| 90 Days Reporting |       |
|  |  |
| Not Subject to Reporting |       |
|  |  |
| Property in Transit |       |
|  |  |
| Extra Expense |       |

|  |  |
| --- | --- |
| Course of Construction |       |

|  |  |  |
| --- | --- | --- |
| **Deductibles** |  |  |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Earthquake – 3% of Values Subject to minimum |       | [ ]  Yes [ ]  No |
| Earthquake – 5% of Values Subject to Minimum |       | [ ]  Yes [ ]  No |
| Flood |       | [ ]  Yes [ ]  No |
| ALl Other Losses |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Policy Form** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| **Manuscript Wording Including:** |
| Valuable Papers |       | [ ]  Yes [ ]  No |
| Accounts Receivable |       | [ ]  Yes [ ]  No |
| Fine Arts |       | [ ]  Yes [ ]  No |
| Course of Construction |       | [ ]  Yes [ ]  No |
| Debris Removal |       | [ ]  Yes [ ]  No |
| Expediting Expense |       | [ ]  Yes [ ]  No |
| Fire Fighting Expense |       | [ ]  Yes [ ]  No |
| Consequential Damage by Service Interruption |       | [ ]  Yes [ ]  No |
| Electronic Data Processing Equipment and Media Coverage (INcl. Mechanical and Electrical Breakdown) |       | [ ]  Yes [ ]  No |
| Pollution Cleanup and Removal  |       | [ ]  Yes [ ]  No |
|       per Occurrence |       | [ ]  Yes [ ]  No |
|       aggregate |       | [ ]  Yes [ ]  No |
| Defense Costs |       | [ ]  Yes [ ]  No |
| Radioactive Contamination |       | [ ]  Yes [ ]  No |
| Consequential Loss |       | [ ]  Yes [ ]  No |
| Professional Fees |       | [ ]  Yes [ ]  No |
| Personal Effects of Employees and Officers –       per person |       | [ ]  Yes [ ]  No |
| Money and Stamps |       | [ ]  Yes [ ]  No |
| Lawns, Trees and Shrubs |       | [ ]  Yes [ ]  No |
| Physical Damage by Civil Authority |       | [ ]  Yes [ ]  No |
| Interruption by Civil Authority – 8 weeks |       | [ ]  Yes [ ]  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Ingress/Egress – 8 weeks |       | [ ]  Yes [ ]  No |
| Service Interruption |       | [ ]  Yes [ ]  No |
| Contingent BI and Extra Expense including but not limited to Contributing and Recipient Premises |       | [ ]  Yes [ ]  No |
| Permission for Unlimited Vacancy |       | [ ]  Yes [ ]  No |
| Breach of Conditions |       | [ ]  Yes [ ]  No |
| Control of Damaged Stock |       | [ ]  Yes [ ]  No |
| Severability of Interest |       | [ ]  Yes [ ]  No |
| Scope of Coverage |       | [ ]  Yes [ ]  No |
| Errors and Omissions clause |       | [ ]  Yes [ ]  No |
| Joint Loss agreement |       | [ ]  Yes [ ]  No |
| Cancellation – 90 days notice |       | [ ]  Yes [ ]  No |

Property Technical Information

|  |  |
| --- | --- |
|  |  |
| Name: |       |
|  |  |
| Location: |       |
|  |  |
| Date: |       |
|  |  |
| Inspected By: |       |
|  |  |
| Conferred with: |       |
|  |  |
| Number of Employees: |       |
|  |  |
| Hours of Operation: |       |
|  |  |
| **Construction** |  |
|  |  |
| Ground Floor Area: |       | Number of Storey’s: |       |
|  |
| Exterior Walls: | [ ]  Concrete Block | [ ]  Concrete Panels  | [ ]  Reinforced Concrete | [ ]  Concrete |
|  |  |  |  |  |
| Supporting Walls: | [ ]  Steel  | [ ]  Wood  |  |  |
|  |  |  |  |
| Ground Floor: | [ ]  Wood Block | [ ]  Reinforced Concrete  | [ ]  Steel with Concrete |
|  |  |  |  |
| Other Floors: | [ ]  Wood Block | [ ]  Reinforced Concrete  | [ ]  Steel with Concrete |
|  |  |  |  |  |
| Roof: | [ ]  Concrete | [ ]  Metal  | [ ]  Steel / Wood Deck | [ ]  Wood |
|  |  |
| Comments: |       |
|  |  |
| Common Hazards: | Heating Systems |       |
|  |  |
|  | Utilities |       |
|  |  |
| Process Hazards: |       |
|  |  |
|  |  |
| **Protection** |  |
|  |  | Alarms Local | Alarms Central Station |
| Automatic Sprinklers: | % | [ ]  Yes [ ]  No  | [ ]  Yes [ ]  No  |
|  |  |  |
| Burglar Protection: | Describe: |       |
|  |  |  |
| Other Fire Protection: | Describe: |       |
|  |  |  |  |
| Watchman Service: | [ ]  Yes [ ]  No  | Describe:  |       |
| Portable Fire Extinguishers | [ ]  Yes [ ]  No |
|  |  |
| Hand Hoses | [ ]  Yes [ ]  No |
|  |  |
| Hydrants: | Within 100 m – 350 ft | [ ]  Yes [ ]  No |
|  |  |  |
|  | Comments: |       |
|  |  |  |
| Water Supply | City Mains? | [ ]  Yes [ ]  No  |
|  |  |  |
|  | Other? |       |
|  |  |  |
| Fire Department | [ ]  Fully Paid [ ]  Volunteer  |  |
|  |  |  |  |  |
|  | Distance from the site (kms) |       | Distance from Site (miles) |       |
|  |  |  |  |  |
|  |  |  | Distance to site (metres/feet) |       |
|  |  |  |  |  |
| Exposures: | North: |       |
|  |  |  |
|  | South: |       |
|  |  |  |
|  | East: |       |
|  |  |  |
|  | West: |       |
|  |  |  |  |  |
| Flood Risks: | Distance to open body of water (meters) |       | (feet) |       |
|  |  |
| Additional Comments: |       |

Estimated Property Values

|  |  |
| --- | --- |
|  |  |
| Date : |       |

Location address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Type** | **Information / Description** | **values insured**  |
| Location |  |  |
| Construction |  |  |
| Building |  |  |
| Equipment |  |  |
| Stock |  |  |
| Business Interior |  |  |
| **Total** |  |  |

Location address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Type** | **Information / Description** | **values insured**  |
| Location |  |  |
| Construction |  |  |
| Building |  |  |
| Equipment |  |  |
| Stock |  |  |
| Business Interior |  |  |
| **Total** |  |  |

Location address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Type** | **Information / Description** | **values insured**  |
| Location |  |  |
| Construction |  |  |
| Building |  |  |
| Equipment |  |  |
| Stock |  |  |
| Business Interior |  |  |
| **Total** |  |  |

 Include Office Contents and EDP Equipment / Media / Extras Expense

Property Loss History

**Summary by Policy Year : From** **To**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Policy Year** | **Net Amount Paid (# Claims)** | **Adj. Expenses** | **Outstanding** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Boiler and Machinery

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |

|  |  |
| --- | --- |
| Named Insured |       |
|  |  |
| Locations Insured |       |
|  |  |
| Additional Named Insured |       |
|  |  |
| Mailing Address |       |
|  |  |
| Term | From |       | To |       |

|  |
| --- |
| **Property Damage** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Standard Comprehensive form |       | [ ]  Yes [ ]  No |
| Covering a Sudden and Accidental Breakdown of all Boilers |       | [ ]  Yes [ ]  No |
| Pressure Vessels |       | [ ]  Yes [ ]  No |
| Mechanical and Electrical Machinery and Apparatus |       | [ ]  Yes [ ]  No |
| Excluding production Machinery |       | [ ]  Yes [ ]  No |
| Also Quote Production Machinery |       | [ ]  Yes [ ]  No |
| Valuation – Repair or Replacement Cost |       | [ ]  Yes [ ]  No |
| Business Interruption |       | [ ]  Yes [ ]  No |
| Gross Profits –Value $       24 month Period of Indemnity |       | [ ]  Yes [ ]  No |
| Extra Expense – Value $       (100% First Month) |       | [ ]  Yes [ ]  No |
| Any One Loss Combined Property Damage/Business Interruption |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Deductibles** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Property Damage |       | [ ]  Yes [ ]  No |
| 24 Hour Waiting Period – Business Interruption |       | [ ]  Yes [ ]  No |
| Extra Expense |       | [ ]  Yes [ ]  No |
| Sub Limits |       | [ ]  Yes [ ]  No |
| Expediting Expenses |       | [ ]  Yes [ ]  No |
| Water Damage |       | [ ]  Yes [ ]  No |
| Ammonia Contamination |       | [ ]  Yes [ ]  No |
| PCB Contamination |       | [ ]  Yes [ ]  No |
| Professional Fees |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Coverage Extensions** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Cancellation in 60 Days |       | [ ]  Yes [ ]  No |
| By-Laws – Included up to Policy Limit |       | [ ]  Yes [ ]  No |
| Off Premises Heat and/or Light |       | [ ]  Yes [ ]  No |
| Stock at Selling Price |       | [ ]  Yes [ ]  No |
| Interruption by Civil authority – up to 2 Weeks |       | [ ]  Yes [ ]  No |
| Amended (in use connected, ready for use) |       | [ ]  Yes [ ]  No |
| Brands/Labels |       | [ ]  Yes [ ]  No |
| Boilers, Pressure Vessels, Electrical, Mechanical Machines, including/excluding Production Machines |       | [ ]  Yes [ ]  No |
| Business Interruption – Profits |       | [ ]  Yes [ ]  No |
| Gross Rentals |       | [ ]  Yes [ ]  No |
| Extra Expense |       | [ ]  Yes [ ]  No |
| Consequential Damage (no co-insurance) |       | [ ]  Yes [ ]  No |
| Definition of Accident Sudden and Accidental Breakdown |       | [ ]  Yes [ ]  No |
| Limits of Liability |       | [ ]  Yes [ ]  No |

|  |  |
| --- | --- |
| Locations Insured : |       |
|  |  |
| Claims History : |       |

Boiler and Machinery Loss History Summary by Policy Year: From       to

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Policy Year** | **Net $ Paid (# claims)** | **Adj. Expenses** | **Outstanding** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Commercial General Liability

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |

|  |  |
| --- | --- |
| Named Insured |       |
|  |  |
| Additional Named Insured |       |
|  |  |
| Mailing Address |       |
|  |  |
| Term | From |       | To |       |

|  |
| --- |
| **Limits/Coverage Required** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Bodily Injury and property Damage per occurrence |       | [ ]  Yes [ ]  No |
| Annual Aggregate products and Completed Operations |       | [ ]  Yes [ ]  No |
| Tenant’s Legal Liability per Occurrence |       | [ ]  Yes [ ]  No |
| Employee Benefits Liability per Occurrence and Aggregate |       | [ ]  Yes [ ]  No |
| Incidental Medical Malpractice Liability per Occurrence |       | [ ]  Yes [ ]  No |
| Advertising Liability per Occurrence |       | [ ]  Yes [ ]  No |
| Non-Owned automobile per Occurrence |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Extensions** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| products/completed operations (Broad Form) |       | [ ]  Yes [ ]  No |
| personal injury (Nil participation) |       | [ ]  Yes [ ]  No |
| occurrence property damage |       | [ ]  Yes [ ]  No |
| employer's liability (excludes U.S.A) |       | [ ]  Yes [ ]  No |
| contingent employer's liability |       | [ ]  Yes [ ]  No |
| employees as additional Named Insured |       | [ ]  Yes [ ]  No |
| tenant's legal liability ("all risks")  |       | [ ]  Yes [ ]  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| non-owned automobile including SEF 94 ("All Perils" $50,000 limit) & 96 |       | [ ]  Yes [ ]  No |
| Cross Liability |       | [ ]  Yes [ ]  No |
| broad form property damage |       | [ ]  Yes [ ]  No |
| medical payments ($10,000 each)Cancellation – 90 Days |       | [ ]  Yes [ ]  No |
| broad form vendor's |       | [ ]  Yes [ ]  No |
| worldwide coverage |       | [ ]  Yes [ ]  No |
| cancellation clause 90 days |       | [ ]  Yes [ ]  No |
| Certificate Holders added as additional Insured |       | [ ]  Yes [ ]  No |
| Owned and Non-Owned Watercraft |       | [ ]  Yes [ ]  No |
| Blanket Contractual (Including verbal if contract within 120 days of agreement) |       | [ ]  Yes [ ]  No |
| Incidental Medical Malpractice |       | [ ]  Yes [ ]  No |
| Employee Benefits Liability |       | [ ]  Yes [ ]  No |
| Advertising Liability |       | [ ]  Yes [ ]  No |
| Fire Fighting Liability |       | [ ]  Yes [ ]  No |
| Limited Pollution (IBC Form 2313) including Hostile Fire |       | [ ]  Yes [ ]  No |
| Notice of loss as soon as practicable  |       | [ ]  Yes [ ]  No |
| Pay on behalf Insuring Agreement |       | [ ]  Yes [ ]  No |
| Personal Injury includes mental anguish, shock, discrimination, humiliation, and harassment |       | [ ]  Yes [ ]  No |
| Owners/Contractors Protective |       | [ ]  Yes [ ]  No |
| Cross Liability/Severability of Interest |       | [ ]  Yes [ ]  No |
| Automobile Exclusion amended to cover loading and unloading, maintenance and attached machinery |       | [ ]  Yes [ ]  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Past & Present officers, executives, directors, employees, stock-holders, volunteers, social club members as Additional Insured |       | [ ]  Yes [ ]  No |
| Automatic Coverage on newly acquired or created organizations |       | [ ]  Yes [ ]  No |
| Blanket Contractual – Non Reporting |       | [ ]  Yes [ ]  No |
| Elevator Collision |       | [ ]  Yes [ ]  No |
| Watercraft up to 50 feet |       | [ ]  Yes [ ]  No |
| Unintentional Errors & Omissions |       | [ ]  Yes [ ]  No |
| Broad Definition of Insured including partnership and Joint Ventures |       | [ ]  Yes [ ]  No |
| Broad Form Vendors |       | [ ]  Yes [ ]  No |
| Worldwide Territory |       | [ ]  Yes [ ]  No |
| Cancellation – 90 Days |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Deductibles** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Each Property Damage Occurrence |       | [ ]  Yes [ ]  No |
| Each claim – Employee Benefits Liability |       | [ ]  Yes [ ]  No |
| Each Claim – Tenants legal Liability |       | [ ]  Yes [ ]  No |
| Each Claim – Legal Liability Damage to Hired autos |       | [ ]  Yes [ ]  No |

Commercial General Liability Questionnaire

**GENERAL INFORMATION**

Insured Name

Address

Telephone       Agent

Agency Address

Telephone       Fax       E-mail

Policy Effective Date

1. How long has the insured been in business?

 (Attach copies of latest annual report and balance sheet)

2. Is the insured a non-profit corporation? [ ]  Yes [ ]  No

 If No, describe

3. Insured Website

4. Name of director

5. Business manager

6. Annual budget       Fiscal year

7. Describe the insured’s funding

8. How is the insured’s facility licensed?      (Attach copies of all licenses)

9. Describe the operations

10. Lines of business submitted?

11. Include the **following** items:

A) [ ]  Loss runs for past 5 years

B) [ ]  Hiring and screening practices

 C) [ ]  Financial Statements

 D) [ ]  Brochures

12. Has any insurer cancelled, declined, or refused renewal? [ ]  Yes [ ]  No

 If yes, why?

13. Has any license ever been suspended or revoked? [ ]  Yes [ ]  No

 If Yes, explain:

14. Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines?

 [ ]  Yes [ ]  No If Yes, explain:

15. Is applicant accredited by:

 [ ]  JCAHO [ ]  CARF [ ]  COA [ ]  Other:

16. List all association memberships or affiliations:

**Part I**  **Social Services**

 *Section 1)* **Premises/Operations Information**

**A) Facility operated by Applicant:** [ ]  Owned by Applicant [ ]  Leased by Applicant

If owned does Applicant lease out any portion of the facility to tenants? [ ]  Yes [ ]  No

If Yes, describe occupancy of the tenants, including type of operations:

If Yes, are tenants required to carry liability insurance for their occupancy? [ ]  Yes [ ]  No

If Yes, what is the minimum liability limit Applicant requires of the tenant? $

Is Applicant always added as an Additional Insured to the tenant’s liability policy? [ ]  Yes [ ]  No

Built in:       Square Footage:      Sq. Ft. Total Number Floors:

Construction of building: [ ]  Frame [ ]  Brick [ ]  Non-Combustible [ ]  Fire Resistive

Does Applicant provide transportation to Clients? [ ]  Yes [ ]  No

**B) Protective Devices/Safety Information**

Automatic Sprinklers [ ]  Yes [ ]  No

Heat Sensors [ ]  Yes [ ]  No

Smoke Detectors [ ]  Yes [ ]  No

If Yes, does each room and hallway have a smoke detector? [ ]  Yes [ ]  No

If Yes, smoke detectors are [ ]  Electronic [ ]  Battery Operated

Fire Extinguishers [ ]  Yes [ ]  No If Yes, how many on the premises?

Fire Escapes [ ]  Yes [ ]  No If Yes, how many on the premises?

Fire Alarms [ ]  Yes [ ]  No If Yes: [ ]  Central Station [ ]  Local Alarm [ ]  None

Distance to nearest fire station?      Distance to nearest fire hydrant?

Does Applicant have a written emergency evacuation plan? [ ]  Yes [ ]  No

 Are there sign in/sign out procedures in place for [ ]  Clients [ ]  Staff [ ]  Visitors

 Type of security provided for the protection of your clients? [ ]  Guards [ ]  Video surveillance [ ]  Other

Are there procedures to monitor client/staff activities? [ ]  Yes [ ]  No

What preventive measures are taken to avoid clients from entering non-permitted areas of the facility?

 Does insured have procedures for staff to report any incidents including meetings to discuss such incidents to safeguard location [ ]  Yes [ ]  No

**C) Swimming Pools**

Does the Applicant utilize swimming facilities? [ ]  Yes [ ]  No

If Yes: [ ]  On Premises [ ]  Off Premises Minimum age allowed in water:

If No, does Applicant anticipate using swimming facilities in the future? [ ]  Yes [ ]  No

If Yes, Explain

Are pools used exclusively for Clients? [ ]  Yes [ ]  No

If No, Explain

Does the pool have a diving board? [ ]  Yes [ ]  No Does the pool have a slide? [ ]  Yes [ ]  No

Are pool depths marked? [ ]  Yes [ ]  No Is the pool area fenced? [ ]  Yes [ ]  No

Is there a self-locking gate? [ ]  Yes [ ]  No Is supervision adequate? [ ]  Yes [ ]  No

Are Lifeguards on duty at all times when Clients are using the pools? [ ]  Yes [ ]  No

Are all Lifeguards certified? [ ]  Yes [ ]  No

Is the walking surface around pool in good condition? [ ]  Yes [ ]  No

**D) Contractors Liability**

Does the Applicant contemplate any construction activity in the next year? [ ]  Yes [ ]  No

If Yes, describe planned construction activity and estimated contract costs:

**E) Products/Completed Operations**

Does the Applicant sell goods or services to members of the public (other than to Clients) [ ]  Yes [ ]  No

**Types of Products:**

Annual Receipts: $

**Types of Services:**

Annual Receipts: $

 *Section 2)* **Special Fund Raising / Sports Events** [ ]  *Does not apply*

1. Name of Applicant:

2. Producer:

3. Name of Additional Insured(s):

4. Their Interest:

5. List Date(s) of Event(s):

6. List Location(s) of Event(s):

7. Description of Event(s) (Use additional space if necessary):

8. Describe Security Protection:

9. Seating Capacity:       Type of Seats:

10. Number of Grandstands (if any):       Permanent:       or Temporary:

11. Estimated Attendance:       Ticket Price:

12. Estimated gross receipts:

13. Number of teams:       Number of players per team:

14. Number of games played:       Duration of season/meet:

15. Age range:       to       Applicants ratio of supervisors to children:       to

16. Is contractual required? [ ]  Yes [ ]  No (If Yes, enclose a copy of the agreement)

17. Has/Have similar events been held in the past? [ ]  Yes [ ]  No

18. Any alcoholic beverages being served at the event? [ ]  Yes [ ]  No

 If yes, who is serving?

19. Additional Insured Interest being required? [ ]  Yes [ ]  No

20. Total number of events expected during the year:

 *Section 3)* **Sexual Misconduct** [ ]  *Does not apply*

 **Current Limits:** **Occurrence / Aggregate**

 1. What is the age group of clients?

2. What is the ratio of staff to clients?

3. Is there more than one person responsible for the welfare of any single client? [ ]  Yes [ ]  No

 If Yes, please describe:

4. Are there rules or guidelines prohibiting closed door one-on-one meetings? [ ]  Yes [ ]  No

 If No, describe why unnecessary:

5. Are there written complaint procedures and are they displayed prominently? [ ]  Yes [ ]  No

 If No, describe why unnecessary:

6. Do you have written formal hiring procedures? (If Yes, please submit written procedures) [ ]  Yes [ ]  No

 a. How are employees screened?

 b. Are at least three references secured on all prospective employees? [ ]  Yes [ ]  No

 c. Are prospective employees checked with the Child Abuse Register and with law enforcement agencies for

 criminal records? [ ]  Yes [ ]  No

 If No, please describe steps taken to ensure that these individuals are suited for job responsibilities:

 d. Has any current employee refused to be fingerprinted and checked with law enforcement

 agencies? [ ]  Yes [ ]  No

7. Do all employees meet the minimum mandated educational or professional experience level for the position

 assigned? [ ]  Yes [ ]  No If No, please explain:

8. Do volunteers work directly with clients? [ ]  Yes [ ]  No

9. Have any employees been the subject of a child abuse/neglect investigation? [ ]  Yes [ ]  No

 If Yes, what were the results of the investigation?

10. Have there ever been any alleged or actual incidents regarding abuse or molestation? [ ]  Yes [ ]  No

 Please describe:
11. For residential risks, what steps are taken to ensure that client-to-client contact is avoided, i.e.,

 separating male from female sleeping quarters:

12. Are children of different age groups housed together? [ ]  Yes [ ]  No

 If Yes, please describe:

13. Are children left alone without any adult supervision? [ ]  Yes [ ]  No

14. List situations where an employee or volunteer has direct contact with clients in an unsupervised

 situation without oversight of another staff member: (you may list on a separate sheet should you

 require additional space for this answer)
15. Is any counseling conducted off premises, i.e. clients’ or counselors’ homes? [ ]  Yes [ ]  No

 If yes, by whom and what type of clients?

16. Is any counseling provided after normal business hours? [ ]  Yes [ ]  No

 If Yes, describe:

17. If transportation is provided, is there more than one adult present at all times? [ ]  Yes [ ]  No

18. What is your procedure on how allegations of abuse are handled?

19. What is your written documentation procedure on how allegations of abuse are handled?

20. Are accused employees removed from client care responsibilities pending outcome of investigation?

 [ ]  Yes [ ]  No If No, please describe:

21. What procedures have been instituted to prevent reoccurrences of previous events?

 *Section 4)* **Foster Care / Adoption** [ ]  *Does not apply*

1. Which Foster Care Services do you provide? (Check all that apply)

[ ]  Licensing of the foster family [ ]  Placement decisions

[ ]  Foster Family recruitment, training, and supervision [ ]  Case management

[ ]  Working with the family of origin [ ]  Permanency planning

[ ]  Removal of the child (adolescent and youth) [ ]  Certification of foster family

 from the family or situation

2. Number of foster placements: Last year:       This year:

3. Number of foster families currently certified:

4. Staff count: Case Workers:       Supervisory:       Other:

5. Are there written procedures to review potential foster/adoptive families? [ ]  Yes [ ]  No

6. Are there criminal background checks for member of foster families? [ ]  Yes [ ]  No

7. Total number of hours/days of training for foster families:       Hours:       Days:

8. Are there follow-up visits after placement? [ ]  Yes [ ]  No If Yes, how often during

 the year?

9. Are there adoption services? [ ]  Yes [ ]  No If Yes, total number of expected adoptions

 during the year?

10. Any international adoptions? [ ]  Yes [ ]  No If Yes, total number of expected adoptions

 during the year?

11. Are there criminal background checks for member of foster families? [ ]  Yes [ ]  No

12. What percentage of insured’s operation involves Foster Care?       Adoption?

13. Does the agency have an adequate number of staff for the foster/adoptive families and

 children served? [ ]  Yes [ ]  No

14. Is the staff assigned adequately trained? [ ]  Yes [ ]  No

15. Does the agency operate in accordance with applicable laws/regulations? [ ]  Yes [ ]  No

 *Section 5)* **Day Care Center / Nursery School Information** [ ]  *Does not apply*

Location Number(s):

1. Description of premises:

 Private Home [ ]  Commercial Building [ ]  School [ ]

2. Interest: Owner [ ]  Tenant [ ]

3. Describe affiliation (church, school, other):

4. Part occupied by applicant (i.e., basement, 1st floor, 2nd floor):

5. Area occupied (sq. ft. dimensions):

6. Construction of building: [ ]  Frame [ ]  Brick [ ]  Non-Combustible [ ]  Fire Resistive

7. Number of floors:      Age of building:      Type of heating:

8. Does applicant have a play area: [ ]  Yes [ ]  No If Yes, describe equipment and list security measures

 (e.g. locked gates etc)

9. Any “Yes” answers to the following must be described in remarks below (attach separate sheet if necessary):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Pools on the premises (must be fenced) | [ ]  Yes | [ ]  No | Animals, pets | [ ]  Yes | [ ]  No |
| Physically/Mentally handicapped or developmentally disabled children  | [ ]  Yes | [ ]  No | Gymnastic equipment | [ ]  Yes | [ ]  No |
| Nurses, Therapists, Counselors | [ ]  Yes | [ ]  No | Unique/unusual teaching techniques | [ ]  Yes | [ ]  No |
| Field trips | [ ]  Yes | [ ]  No |  |

Remarks:

10. Is applicant licensed or certified as a Day Care Center/Nursery School? [ ]  Yes [ ]  No

 If Yes, please attach a copy of the license.

 If No, explain:

11. Has applicant ever been cited by authorities for day care violations with or without suspension or revocation of

 certification or license? [ ]  Yes [ ]  No If Yes, explain in detain on separate sheet.

12. Does applicant require a release of liability from all children? [ ]  Yes [ ]  No

 If no, will you institute such a program? [ ]  Yes [ ]  No

13. Applicant is licensed to care for children ages     to    . (If no license required, state maximum numbers)

 Number children:

 Under age 2:       From 3 to 5:       From 6 to 10:       Over age 10:

14. Applicant's ratio of supervisors to children is       to

15. Applicant operates     days per week from      to     . Average daily attendance of       children.

 *Section 6)*  **Residential Care / Inpatient Care Facility** [ ]  *Does not apply*

1. Please list location numbers with residential care/inpatient facilities:

2. Full description of services rendered (Attach all brochures and promotional material):

3. Is the facility run by an outside management company? [ ]  Yes [ ]  No

 If Yes, describe the relationship:
4. How long under present management?

5. Date established:

6. Indicate estimated: Receipts $      *or* Operating Budget $      Payroll $

7. Is the applicant engaged in, owned by, owned by, associated with, or involved in any other enterprise?

 [ ]  Yes [ ]  No If Yes, describe:

8. Are you currently licensed for operation by the proper regulatory authorities? [ ]  Yes [ ]  No

 (Attach a copy of the license.)
 Is the license conditional? [ ]  Yes [ ]  No
 If Yes, explain:

 Has the license ever been revoked? [ ]  Yes [ ]  No

 If Yes, explain:

 M - Male

 Total # Age of F – Female Length Client-staff

9. **Type of facility**: of beds residents or both of stay ratio

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ] Alcohol or Drug - Rehab |       |       |       |       |       |
| [ ] Alcohol or Drug - Treatment |       |       |       |       |       |
| [ ] Alcohol or Drug - Detoxification  |       |       |       |       |       |
| [ ] Psychiatric Care  |       |       |       |       |       |
| [ ] Shelter for runaways,abused spouses,foster children  |       |       |       |       |       |
| [ ] Homeless Shelter Facility  |       |       |       |       |       |
| [ ] School: (state type of school):       |       |       |       |       |       |
| [ ] Group home - Mental/ Physical Rehab |       |       |       |       |       |
| [ ] Group home - Developmentally Disabled |       |       |       |       |       |
| [ ] Group home - Troubled Youth  |       |       |       |       |       |
| [ ] Transitional Housing - Low-income |       |       |       |       |       |
| [ ] Aged - Independent living  |       |       |       |       |       |
| [ ] Aged - including intermediate care  |       |       |       |       |       |
| [ ] Aged - including skilled care  |       |       |       |       |       |
| [ ] Hospice |       |       |       |       |       |
| [ ] Nursing home for senile or aged  |       |       |       |       |       |
| [ ] Other (specify):       |       |       |       |       |       |

 Total number of bed for all facilities:

 How many beds are currently occupied:

 Is the facility (check one): [ ]  Co-ed or [ ]  Single Sex If Co-ed, how are patients segregated and

 Monitored?

 Are clients of different age groups segregated? [ ]  Yes [ ]  No Please describe:

 Number of bedridden clients:

10. **Type of Client at all facilities above**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client** | **Ambulatory** | **Non-Ambulatory** | **Total Client** |
| Substance abuse patients- Rehab |       |       |       |
| Substance abuse patients- Treatment |       |       |       |
| Substance abuse patients- Detoxification |       |       |       |
| Somewhat mentally impaired (i.e. Senile) |       |       |       |
| Seriously mentally impaired (i.e. Alzheimer’s) |       |       |       |
| Aged but mentally and physically fully functional |       |       |       |
| Mentally/Physically disabled requiring intermediate care |       |       |       |
| Mentally/Physically disabled requiring skilled care |       |       |       |
| Other (Specify):       |       |       |       |

11. What floors are the non-ambulatory patients on?       How many patients are on each floor?

12. Are restraints used? [ ]  Yes [ ]  No If yes, attach copies of restraining procedures that are in force.

13. Other operations:

|  |  |
| --- | --- |
| [ ]  Counseling # of visits:        |  |
| [ ]  Home care # of visits:       |  |
| [ ]  Day time care # of clients:      |  |
| [ ]  Other (specify):       |  |

14. If counseling is provided, describe (e.g., group therapy, individual counseling):

15. List other types of services provided (e.g., beautician services, podiatry, dentistry):

 Provided for:       By staff:       By Contractors:

16. Ages of patients:

 [ ]  Under 18 [ ]  18 – 35 yrs old [ ]  36 – 50 yrs old [ ]  51 – 65 yrs old [ ]  Over 65
 Client to Staff Ratio:

17. Precautions taken to keep track of patients:

 Sign out procedures? [ ]  Yes [ ]  No

 Are there alarms on doors to prevent clients from wandering from the residence? [ ]  Yes [ ]  No
 Other:

 Are routine bed checks performed? [ ]  Yes [ ]  No How often?

 Are they logged? [ ]  Yes [ ]  No
18. Do any patients work full or part time jobs? [ ]  Yes [ ]  No

 If Yes, what percentage of patients work:     % What type of work:
19. Are any medications administered? [ ]  Yes [ ]  No

 If Yes, list any medication administered and in what form given (e.g., Methadone, given in

 pill form):

20. Is the insured a: [ ]  Building Owner [ ]  Tenant [ ]  General Lessee

 Name any other tenants on the premises:

21. Explain average length of stay and type of treatment, i.e., alcohol, drug, psychiatric:

22. Is a Registered Nurse or M.D. on duty at all times? [ ]  Yes [ ]  No If No, explain availability:

23. Do staff members carry their own professional liability insurance? [ ]  Yes [ ]  No Explain in Detail:

24. Is any facility used for detoxification (withdrawal) of drug addicts and/or alcoholics? [ ]  Yes [ ]  No

 If Yes, Explain:

 *Section 7)* **Outpatient Facilities** *[ ]  Does not apply*

 Location Number (s):

1. Outpatient Facilities/Treatment

 a. Estimated number of client contacts\*\* per year (excluding Methadone):       Annual Visits:

 b. Methadone maintenance: [ ]  Yes [ ]  No If Yes, estimated doses administered per year:

 c. Counseling: [ ]  Yes [ ]  No

2. Does insured operate a clinic? [ ]  Yes [ ]  No If Yes, annual number of visits:

3. Does the insured operate a crisis hotline? [ ]  Yes [ ]  No If Yes, annual # of calls received:

4. Do you provide any services/programs for ex-offenders? [ ]  Yes [ ]  No If Yes, please describe type of

 offenses:

5. Do you operate an adult day care facility and/or senior day care center? [ ]  Yes [ ]  No

 If Yes, please answer the following:

1. Type of activities/services offered:
2. Total number of clients daily:       Annually:
3. Staff to client ratio:

6. Do you provide a meal delivery service? [ ]  Yes [ ]  No If Yes, annual number of meals served:

7. Do you offer training/vocational programs? [ ]  Yes [ ]  No If Yes, annual number of clients:

 Types of programs offered:

8. Do you offer information or referral services to clients? [ ]  Yes [ ]  No If Yes, annual number of clients:

 Types of referrals offered:

\*\*CLIENT CONTACTS: For the purpose of computing the premium charge, we count the following to

 be a client contact, regardless of the discipline of the counselor:

 1) Individual Counseling: Face-to-Face visit, including Outreach
 2) Group Therapy: Each member of a group, each session
 3) Day Care/Camps: Each client/day counts

 *Section 8)* **Sheltered Workshop** *[ ]  Does not apply*

 Location Number (s):

1. Estimated number of client days per year:

2. Maximum number of clients any one day:

3. Brief description of activities and nature of products:

4. Estimated annual receipts:

5. Do clients work with power equipment? [ ]  Yes [ ]  No

 If Yes, please describe:

6. Is coverage for Products Liability desired? [ ]  Yes [ ]  No

7. How is the product sold? [ ]  Wholesale [ ]  Retail [ ]  Jobber [ ]  Direct

8. Are hold harmless agreements given to others in connection with products manufactured by

 applicants? [ ]  Yes [ ]  No

9. Contractual Liability: Attach copy of all contracts to be covered other than the following' lease of

 premises, easement agreements, side tract agreements, agreements required by municipal ordinance,

 elevator maintenance agreement.

10. Any of the following performed:

|  |  |  |
| --- | --- | --- |
| Spray painting: | [ ]  Yes | [ ]  No |
| Discharge of fumes: | [ ]  Yes | [ ]  No |
| Discharge of acids or wastes: | [ ]  Yes | [ ]  No |
| Use of radioactive materials: | [ ]  Yes | [ ]  No |

Describe any hazard, on or away from the premises, not normally existing with this class of business:

 *Section 9)* **Recreational Facilities / Camps** *[ ]  Does not apply*

Location(s):

Limits of Liability Requested:

***PLEASE ANSWER ALL QUESTIONS. IF THEY DO NOT APPLY, INDICATE “NOT APPLICABLE”***

**I) Applicant Premise Information**

1. Name of Facility/Camp (if different than Applicant)
2. Dates of Camp (if applicable)
3. Is the camp accredited by A.C.A? [ ]  Yes [ ]  No

4a. Is the camp a member of another camping association? [ ]  Yes [ ]  No

4b. If yes, which one(s)?

5. Is the facility [ ]  Co-ed [ ]  Boys [ ]  Girls

6. Is the facility [ ]  Day [ ]  Overnight [ ]  Travel

7. Years in Business:       Under Present Management:

8. Please indicate which of following activities campers are involved in:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Horseback riding | [ ]  Wilderness adventure | [ ]  Football | [ ]  Climbing wall |
| [ ]  Archery ranges | [ ]  Hiking | [ ]  Volleyball | [ ]  Basketball |
| [ ]  Canoeing, boating | [ ]  Swimming | [ ]  Boxing/Wrestling | [ ]  Baseball/Softball |
| [ ]  Water sports (waterskiing, etc.) | [ ]  Waterslide | [ ]  Karate/Martial Arts | [ ]  Soccer |
| [ ]  Snow Sports (cross country skiing, snow-shoeing, etc.) | [ ]  Ropes course | [ ]  Other |

9. Please provide details (including safety controls) for all activities the clients will be involved in during the duration

 of their stay:

**II) Premium Basis (If Applicable)**

10. Estimated number of campers per day/week:       Annual:       Age range of campers:

11. Estimated number of days per week?      Weeks per year?

**III) Underwriting Criteria**

12. Total number of staff       Client to staff ratio?

 13. Does the applicant have an accident & health policy? [ ]  Yes [ ]  No

 If yes, who is the carrier, and what is the limit of liability?

 14. Does the applicant require clients to sign waivers? [ ]  Yes [ ]  No

 15. Any hold harmless agreements? [ ]  Yes [ ]  No

 If yes, with whom and what is the nature of the agreement?

16. If *overnight camp*, please answer the following:

1. What type of cooking takes place (deep-fryers, etc.)?

1. What kind of fire suppression system is in the kitchen area?

1. Are the cabins/sleeping areas equipped with hard wired smoke detectors? [ ]  Yes [ ]  No
2. Is there a no smoking policy in place for campers/staff (or a designated smoking area)? [ ]  Yes [ ]  No

Are camp fires allowed, and if so, where & how are flammables stored?

1. Is there an evacuation plan in place (in case of natural disaster or forest fire)? [ ]  Yes [ ]  No

17. Does the facility specialize in camping experiences for physically or developmentally disabled individuals? [ ]  Yes [ ]  No

 If yes, please provide a complete narrative of such program(s) below or on a separate sheet, if necessary:

 *Section 10)* **In-Home Support Services**  *[ ]* *Does not apply*

1. **Services Provided:**

|  |  |  |
| --- | --- | --- |
| [ ]  Nursing Care | [ ]  Speech therapy | [ ]  Bathing |
| [ ]  Changing catheters | [ ]  Social work | [ ]  Laundry |
| [ ]  Infusion therapy | [ ]  Nutrition counseling | [ ]  Meal preparation |
| [ ]  Medical management | [ ]  Repositioning | [ ]  Housework |
| [ ]  Blood testing | [ ]  Restroom aid | [ ]  Dressing |
| *[ ]*  Other:       | [ ]  Other:       | [ ]  Other:       |

2. How long has the program been in place?

3. How many employees provide in-home services?       Volunteers?

4. How many “Nursing” visits (column #1) do you provide annually?

5. How many other visits (columns #2 & #3) do you provide annually?

6. Do you have procedures in place regarding client security?

7. How do you monitor in-home service providers?

 *Section 11)* **Employee Dishonesty Supplement** *[ ]* *Does not apply*

**GENERAL**

1. Total number of employees:       Total number of volunteers:

2. Number of employees who handle money, securities or other property:

3. Is your operation a Non-Profit Organization? [ ]  Yes [ ]  No

4. What is your annual budget?

5. Do you expect the number of employees/volunteers to grow substantially this year? [ ]  Yes [ ]  No

6. Name of current insurance carrier and employee dishonesty limits:

7. Why are you requesting this limit?

**LOSSES**

8. List any losses during the past 5 years: (Include description and amount of loss along with

 remedial action taken to prevent further losses):

9. At the present time, do you suspect any dishonest activity in your operation? [ ]  Yes [ ]  No

10. Has your organization ever contacted authorities to investigate suspected dishonest acts by one of your employees?

[ ]  Yes [ ]  No

 If Yes, please explain circumstance:

**PROTECTIVE CONTROLS**

11. Is an annual audit performed by an outside C.P.A.? [ ]  Yes [ ]  No

12. Will there be an audit by an officer or employee who is a C.P.A.? [ ]  Yes [ ]  No

 How often?       By whom?

13. Are audit reports given directly to the Board of Directors? [ ]  Yes [ ]  No

14. At what level of check amounts are countersignature required on all checks?

 [ ]  $1,000 or less [ ]  $1,001 - $2,500 [ ]  $2,501 - $5,000 [ ]  Over $5,000 [ ]  All Levels

15. Does someone not making deposits or withdrawals reconcile the monthly bank statement? [ ]  Yes [ ]  No

16. Is inventory (example: computers and office equipment) monitored and tracked? [ ]  Yes [ ]  No

17. Is verification or review made on accounts receivables ledger by a staff member other

 than the person(s) normally working with such records? [ ]  Yes [ ]  No

 How often?       By whom (position):

18. Do branch locations of your operation bank locally? [ ]  Yes [ ]  No

 If Yes, are duplicate copies of monthly bank statements & deposit slips sent direct to

 the main office by the bank? [ ]  Yes [ ]  No If Yes, are duplicate copies of monthly

 bank statements & deposit slips sent direct to the main office by the bank? [ ]  Yes [ ]  No

**COMPUTER CONTROLS**

19. Do you use a computer for any accounting, payroll, payment, or banking function? [ ]  Yes [ ]  No

 If Yes, is output reconciled or audited by persons who do not prepare the input or process it? [ ]  Yes [ ]  No

**PURCHASING OR RELATED FUNCTIONS**

20. Are any employees permitted to have a financial interest in firms that supply goods or

 services to your organization? [ ]  Yes [ ]  No

21. Is there a policy prohibiting staff from accepting gifts or favors from suppliers or clients? [ ]  Yes [ ]  No

22. Are purchase orders used? [ ]  Yes [ ]  No If Yes, are they pre-numbered and are copies

 made for accounting department staff? [ ]  Yes [ ]  No

23. Does any one person have sole authority to handle the order placement & disbursement? [ ]  Yes [ ]  No

24. Are suppliers’ invoices matched with related purchase orders & attached to the checks for

 review at the time the checks are signed? [ ]  Yes [ ]  No

25. Are invoices cancelled or stamped “paid” after payment is made to avoid reuse? [ ]  Yes [ ]  No

26. Do you have a positive system to detect payment to fictitious suppliers? [ ]  Yes [ ]  No

 **AUTHORITY OF EMPLOYEES**

27. List the names, positions and tenure of the employees authorized to do any of the following activities:

 Sign Checks:

 Handles Bank Deposits:

 Approve Payroll:

 *Section 12)* **Auto Supplement**  *[ ]  Does not apply*

1. Are patients/clients transported in vehicles? [ ]  Yes [ ]  No

2. Describe the type of occupants:

|  |
| --- |
| [ ]  Physically Handicapped [ ]  Elderly[ ]  Mentally Handicapped [ ]  Non-Ambulatory[ ]  Children [ ]  Other (describe):       |

3. List Safety Measures on board vehicles:

|  |  |  |
| --- | --- | --- |
| * Is seat belt use mandatory?
 | [ ]  Yes | [ ]  No |
| * Is there a matron on board?
 | [ ]  Yes | [ ]  No |
| * Are there wheelchair lifts?
 | [ ]  Yes  | [ ]  No |
| * Are there wheelchair mounts within vehicle?
 | [ ]  Yes  | [ ]  No |
| * Any medical support equipment on board?
 | [ ]  Yes  | [ ]  No |
| * Any first aid equipment on board?
 | [ ]  Yes | [ ]  No |

4. How often are vehicles used?       What are vehicles used for:

5. What is the normal radius of operation?

6. Is there any interstate travel? [ ]  Yes [ ]  No If Yes, please describe:

7. Are professional drivers used? [ ]  Yes [ ]  No

8. Do you order motor vehicle reports on all drivers? [ ]  Yes [ ]  No

9. Do volunteers operate vehicles? [ ]  Yes [ ]  No

10. How are drivers equipped to handle the specific type of occupant?

11. Are all drivers covered by Workers Compensation? [ ]  Yes [ ]  No

12. Any drivers under 25 years of age? [ ]  Yes [ ]  No Over 60 years of age? [ ]  Yes [ ]  No

13. Is a driver log maintained? [ ]  Yes [ ]  No

14. Are any vehicles driven by handicapped personnel? [ ]  Yes [ ]  No

 If Yes, how are vehicles equipped?

15. Is there a formal maintenance program? [ ]  Yes [ ]  No

16. Who services vehicles?

17. Where are vehicles stored overnight?

18. Are there any owned or leased vehicles covered under a different policy? [ ]  Yes [ ]  No

 If yes, explain:

19. Are employees permitted to take vehicles home? [ ]  Yes [ ]  No

 If Yes, how often?

20. Are employees vehicles used? [ ]  Yes [ ]  No If Yes, how often?

21. Are volunteer vehicles used? [ ]  Yes [ ]  No If Yes, how often?

22. Does the insured obtain copies of auto policies from volunteers or employees? [ ]  Yes[ ]  No

23. Any vehicles rented or leased from others? [ ]  Yes [ ]  No

 If Yes, how often?       With or without driver?

 Are certificates of insurance obtained from the lessor? [ ]  Yes [ ]  No

 What limits are required?

 **Hired / Non-owned Auto Information** *[ ]  Does not apply*

1. Any Owned Autos? [ ]  Yes [ ]  No

2. Number of Employees:       Number of Volunteers:

3. Do the employees or volunteers use their own vehicles on behalf of the insured?

 [ ]  Yes [ ]  No If Yes, enter the approximate number of employees/volunteers that use their own vehicle for

 company business:

 Never:       Occasionally:       Frequently:

4. How many drivers run errands using their own vehicles for company business?

5. How many drivers transport clients in their own vehicles for company business?

6. Do you obtain copies of insurance policies for volunteers and employees who use their

 own vehicles? [ ]  Yes [ ]  No

7. Are these records updated at least yearly? [ ]  Yes [ ]  No

8. Do you require insurance limits of at least 100/300/100? [ ]  Yes [ ]  No

 If No, what limits do you require?

9. Are MVR’s checked on volunteers/employees? [ ]  Yes [ ]  No

10. Do you have a driver safety program? [ ]  Yes [ ]  No

11. Are seat belts required to be worn by all occupants? [ ]  Yes [ ]  No

12. In order to obtain non-owned coverage, it is required for your own protection that all employees/volunteers who

 use their own vehicles regularly maintain personal auto limits of 100/300/100 with a copy of current insurance

 limits on file with the non-profit. Are you willing to follow this procedure to protect

 the non-profit? [ ]  Yes [ ]  No

 **Part II**  **Staff Profile**  - **PROFESSIONAL LIABILITY**

 **[ ]  CLAIMS MADE [ ]  OCCURRENCE**

If this is a claims-made policy, please indicate retro date:       (Complete Attachment B)

 **Current Limits:** **Occurrence/Aggregate**

1. Describe professional services provided:

2. Is the agency licensed by the state or by another regulatory agency? [ ]  Yes [ ]  No

 If Yes, please describe:

3. Total client contacts per year:

4. Does the agency have any residential inpatient facilities? [ ]  Yes [ ]  No

 (If you answered “Yes” to question #4, please complete residential section - Part I, Section 6)

5. Please provide the number of each type of caregiver below:

|  |  |  |  |
| --- | --- | --- | --- |
| **Independent Contractor** | **Employed** | **Volunteer** | **TOTAL** |
|  | **Full Time** | **Part Time** | **Full Time** | **Part Time** |
| Homemaker, Home Health, Nurse’s Aide, Sitter, Companion, Bereaval Therapist, Occupational Therapist, Paraprofessional Social Worker, Teacher |  |  |  |  |  |
| LPN, Social Worker (BA), Dietician, Nutritionist, Dental Hygienist, Pharmacy Assistant, Lab Technician, Medical Tech, Radiology Tech, Certified Medical Asst. |  |  |  |  |  |
| Counselor, RN, Social Worker (MA, MSW), Speech Pathologist, Dialysis Tech, Enterstomal Therapist , Clergy |  |  |  |  |  |
| Medical Director , Project Director |  |  |  |  |  |
| Pharmacist |  |  |  |  |  |
| Physical Therapist, Respiratory Therapist, Phlebotomist, Nuclear Medicine Tech, Radiation Therapist |  |  |  |  |  |
| Psychologist |  |  |  |  |  |
| Nurse Practitioner, Physician Assistant, Paramedic, EMT |  |  |  |  |  |
| Psychiatrist, Dentist (\*\*Must complete Attachment A ) |  |  |  |  |  |
| Medical Doctor / D.O. / Podiatrist Acupuncturist (\*\* Must complete Attachment A ) |  |  |  |  |  |
| Other (Client Contact Only) Describe:       |  |  |  |  |  |

Volunteer

**Please include a STAFF PROFILE with your submission.**

 **\*\*Note: For professional coverage on these highlighted staff type above, each and every**

 **Psychiatrist, Medical Doctor, D.O., and Podiatrist must complete “Attachment A”.**

6. Do you have any contractual agreements to provide services? [ ]  Yes [ ]  No

 If Yes, please describe:

Applicant Signature/Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Umbrella Liability Section

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |

|  |  |
| --- | --- |
| Name of Insured: |       |

**Limits of Liability**

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Pre Occurrence | 200,000 | [ ]  Yes [ ]  No  |
| Aggregate Excess of Underlying Coverages & Limits Retentions | 200,000 | [ ]  Yes [ ]  No  |

|  |
| --- |
| **Underlying Policies** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| General Liability |       | [ ]  Yes [ ]  No |
| Automobile |       | [ ]  Yes [ ]  No |
| Garage automobile |       | [ ]  Yes [ ]  No |
| Non-Owned Aircraft |       | [ ]  Yes [ ]  No |
| **Insurers Wording Including** |
| Pay on Behalf Insuring Agreement |       | [ ]  Yes [ ]  No |
| Follow Form |       | [ ]  Yes [ ]  No |
| Broad Form PD |       | [ ]  Yes [ ]  No |
| Blanket Contractual |       | [ ]  Yes [ ]  No |
| Employers’ Liability |       | [ ]  Yes [ ]  No |
| Employee Benefits |       | [ ]  Yes [ ]  No |
| Incidental Medical Malpractice |       | [ ]  Yes [ ]  No |
| Fire Fighting Expense |       | [ ]  Yes [ ]  No |
| Personal Injury |       | [ ]  Yes [ ]  No |
| Real Property CCC |       | [ ]  Yes [ ]  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Named Insured |       | [ ]  Yes [ ]  No |
| No Exclusion for Punitive Damages |       | [ ]  Yes [ ]  No |
| Excess Automobile |       | [ ]  Yes [ ]  No |
| Pollution (IBC 2313) |       | [ ]  Yes [ ]  No |
| Worldwide Territory |       | [ ]  Yes [ ]  No |
| Cancellation – 90 Days Notice |       | [ ]  Yes [ ]  No |

Crime Section

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |

|  |  |
| --- | --- |
| Name of Insured: |       |

|  |
| --- |
| **Limits of Liability** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Employee Theft |       | [ ]  Yes [ ]  No |
| Loss Inside the Premises |       | [ ]  Yes [ ]  No |
| Loss Outside the Premises |       | [ ]  Yes [ ]  No |
| Money Orders and Counterfeit Currency |       | [ ]  Yes [ ]  No |
| Depositors’ Forgery |       | [ ]  Yes [ ]  No |
| Computer Fraud and Funds Transfer Fraud |       | [ ]  Yes [ ]  No |
| Credit Card Forgery |       | [ ]  Yes [ ]  No |
| Client Coverage |       | [ ]  Yes [ ]  No |
| Employee Benefit Coverage |       | [ ]  Yes [ ]  No |

**Retentions**

|  |  |  |
| --- | --- | --- |
| Options : |       |  \*Nil retention for Employee Benefit Plans |

 **Coverages**

|  |
| --- |
| **Limits of Liability** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| 120 days Notice post Discovery of Loss |       | [ ]  Yes [ ]  No |
| Proof of Loss required within 6 months of Discovery |       | [ ]  Yes [ ]  No |
| Funds Transfer Fraud for Money, Securities, Property and Merchandise |       | [ ]  Yes [ ]  No |
| 12 months Discovery Period |       | [ ]  Yes [ ]  No |
| 120 days Notice of Cancellation |       | [ ]  Yes [ ]  No |
| 60 days Notice of Non-renewal |       | [ ]  Yes [ ]  No |
| Audit Expenses for all Insuring Clauses – $250,000 |       | [ ]  Yes [ ]  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Reproduction Costs |       | [ ]  Yes [ ]  No |
| Definition of Employee to include Non-compensated Directors, Officers and Trustees |       | [ ]  Yes [ ]  No |
| Temporary Employees excess of Agency coverage |       | [ ]  Yes [ ]  No |
| Part-time, Contract or Seasonal Employees |       | [ ]  Yes [ ]  No |
| Students |       | [ ]  Yes [ ]  No |
| Retired Employees acting as Consultants |       | [ ]  Yes [ ]  No |
| Automatic Acquisition coverage < 20% of Assets, 90 day Notice provision |       | [ ]  Yes [ ]  No |
| Prior Fraud Tolerance Level of $25,000 |       | [ ]  Yes [ ]  No |
| Unidentifiable Employee clause |       | [ ]  Yes [ ]  No |
| Ex-employees covered for 90 days post termination |       | [ ]  Yes [ ]  No |
| Employee Cross-over Rider |       | [ ]  Yes [ ]  No |
| Employee Benefit Plans included as Insureds |       | [ ]  Yes [ ]  No |
| Worldwide Territory |       | [ ]  Yes [ ]  No |
| Designated Reps under “Notice,” Prior Dishonesty,” “Discovery,” and “Cancellation” clauses |       | [ ]  Yes [ ]  No |
| Toll Fraud coverage |       | [ ]  Yes [ ]  No |
| Worldwide Currencies under Money Orders and Counterfeit Currency |       | [ ]  Yes [ ]  No |
| Include “Telefacsimile” under Funds Transfer Fraud |       | [ ]  Yes [ ]  No |
| Professional Liability Loss History |       | [ ]  Yes [ ]  No |

**Crime Losses Summary by Policy Year**

|  |
| --- |
| **Summary by Policy Year: From ( ) to ( )** |
| **Policy Year** | **Net Amount Paid (# Claims)** | **Adj. Expenses** | **Outstanding** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

Automobile Fleet Information

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |
|  |  |
| Named Insured: |       |
|  |  |
| **Vehicles** All vehicles owned by, licensed and/or leased to the named insured. |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Third Party Liability |       | [ ]  Yes [ ]  No |
| Accident Benefits (per provincial requirements) |       | [ ]  Yes [ ]  No |
| Loss or Damage to Insured Automobile |       | [ ]  Yes [ ]  No |
| All Perils – Deductible |       | [ ]  Yes [ ]  No |
| Comprehensive – deductable |       | [ ]  Yes [ ]  No |
| Specified Perils – deductable |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Endorsements** |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| OPCF 2 – Permission to Drive Other Automobiles |       | [ ]  Yes [ ]  No |
| OPCF 4A – Permission to Carry Explosives |       | [ ]  Yes [ ]  No |
| OPCF 4B – Permission to Carry Radioactive Material |       | [ ]  Yes [ ]  No |
| OPCF 5 – Permission to Rent or Lease Automobiles |       | [ ]  Yes [ ]  No |
| OPCF 6A – Permission to Carry Paying Passengers |       | [ ]  Yes [ ]  No |
| OPCF 20 – Coverage for Transportation Replacement  |       | [ ]  Yes [ ]  No |
| OPCF 21B – Blanket Coverage |       | [ ]  Yes [ ]  No |
| OPCF 27 – Physical Damage to Non-Owned Automobiles |       | [ ]  Yes [ ]  No |
| OPCF 27B – Business Operations: Physical Damage to Non-Owned Autos |       | [ ]  Yes [ ]  No |
| OPCF 43/43A – Removing Deprecation Deduction (      Months) |       | [ ]  Yes [ ]  No |
| OPCF 44R – Family Protection Endorsement |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Others**  |
| Blanket Lessors |       | [ ]  Yes [ ]  No |
| Cross liability |       | [ ]  Yes [ ]  No |
| Cancellation – 90 Days Notice |       | [ ]  Yes [ ]  No |
| Contingent Profit Agreement |       | [ ]  Yes [ ]  No |
| **Endorsements**  |
| QEF 2 – Drive Other Automobiles  |       | [ ]  Yes [ ]  No |
| QEF 4A – Transportation of Explosives |       | [ ]  Yes [ ]  No |
| QEF 4B – Transportation of Radioactive Materials |       | [ ]  Yes [ ]  No |
| QEF 5A – Lease or Leasing |       | [ ]  Yes [ ]  No |
| QEF 20 – Loss of Use Extension |       | [ ]  Yes [ ]  No |
| QEF 21B – Blanket Fleet Coverage |       | [ ]  Yes [ ]  No |
| QEF 27 – Civil Liability for Damage to Non Owned Automobiles |       | [ ]  Yes [ ]  No |
| QEF 34 – Accident Benefits |       | [ ]  Yes [ ]  No |
| QEF 43 – Change to Loss Payment |       | [ ]  Yes [ ]  No |
| **Endorsements**  |
| SEF 2 – Drive Other Automobiles  |       | [ ]  Yes [ ]  No |
| SEF 4A – Permission to carry explosives |       | [ ]  Yes [ ]  No |
| SEF 4B – Permission to carry Radioactive material |       | [ ]  Yes [ ]  No |
| SEF 5 – Permission to Rent or Lease |       | [ ]  Yes [ ]  No |
| SEF 6A – Permission Carry Passengers for Compensation |       | [ ]  Yes [ ]  No |
| SEF 20 – Loss of Use Extension |       | [ ]  Yes [ ]  No |
| SEF 21B – Blanket Fleet Coverage |       | [ ]  Yes [ ]  No |
| SEF 21D – Express Coverage Blanket Fleet (mb, sk, bc) |       | [ ]  Yes [ ]  No |
| SEF 27 – Legal Liability for Damage to Non Owned Automobiles |       | [ ]  Yes [ ]  No |
| SEF 43R – Limited Waiver of Depreciation -       months |       | [ ]  Yes [ ]  No |
| SEF 43L – Limited Waiver of Depreciation -       months |       | [ ]  Yes [ ]  No |
| SEF 44 – Family Protection Endorsement |       | [ ]  Yes [ ]  No |
| BCSEF 41 – Limitation of Third Party Liability to Excess Insurance (BC) |       | [ ]  Yes [ ]  No |
| EEF 1 – Saskatchewan Excess |       | [ ]  Yes [ ]  No |

|  |
| --- |
| **Others** |
| Manitoba Excess |       | [ ]  Yes [ ]  No |
| Cancellation – 90 days notice |       | [ ]  Yes [ ]  No |
| Blanket Lessors |       | [ ]  Yes [ ]  No |
| NFLD – Basic Accident Benefits |       | [ ]  Yes [ ]  No |
| Cross Liability  |       | [ ]  Yes [ ]  No |
| Contingent Profit Agreement |       | [ ]  Yes [ ]  No |

**Automobile Business Purpose**

|  |  |
| --- | --- |
| **Fleet Information** | **Comment** |
| 1. Present company and policy #
 |  |
| 1. How long present company had the risk
 |  |
| 1. Applicant’s business
 |  |
| 1. Number of vehicles in each of preceding 3 years
 |  |
| 1. Use of vehicles and types of goods hauled
 |  |
| 1. Special Endorsements Required?
 | [ ]  Yes [ ]  No | Explain:  |
| 1. Filings Required?
 | [ ]  Yes [ ]  No | Explain: |
| 1. Radius of Operations
 |  |
| 1. U.S. Exposures?
 | [ ]  Yes [ ]  No | Explain: |
| 1. Describe screen and testing procedures of new and existing drivers (especially commercial vehicles)
 |  |
| 1. Are MVR’s ordered for all new drivers?
 | [ ]  Yes [ ]  No | Explain: |
| 1. Are MVR’s Ordered on other than new drivers?
 | [ ]  Yes [ ]  No | Explain: |
| 1. Describe loss prevention and/or fleet safety programs in place (include vehicle maintenance)
 |  |

**Schedule of Vehicles**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Prov** | **Year** | **Make/Model** | **Serial Number** | **Use/Radius of Operations (KMs)** | **Cost NewIncl. Equipment** |
|  |  |  |  |  | $ |
|  |  |  |  |  | $ |
|  |  |  |  |  | $ |

**Driver Information**

|  |  |  |
| --- | --- | --- |
| **Name of Driver** | **Licence Number** | **Cell Phone** |
|  |  |  |
|  |  |  |
|  |  |  |

Automobile Loss History

**Automobile Loss History Detailed : From       To**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Cause / Description** | **Net Amt. Paid** | **Ded.****Amount** | **AdjustExpenses** | **Outstanding** | **Gross Total** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |

Garage Automobile Section

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |

|  |  |
| --- | --- |
| Insured: |       |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| OAP 4, QPF 4, SF 4 – Standard Garage Automobile |       | [ ]  Yes [ ]  No |
| Third Party Liability |       | [ ]  Yes [ ]  No |
| Accident Benefits – Options as per Provincial Requirements |       | [ ]  Yes [ ]  No |
| Uninsured Automobile |       | [ ]  Yes [ ]  No |
| Legal Liability for Damage to Customers’ Vehicles |       | [ ]  Yes [ ]  No |
| Collision or Upset |       | [ ]  Yes [ ]  No |
| Any one vehicle |       | [ ]  Yes [ ]  No |
| Deductable |       | [ ]  Yes [ ]  No |
| Specified Perils |       | [ ]  Yes [ ]  No |
| Each Location |       | [ ]  Yes [ ]  No |
| Deductable |       | [ ]  Yes [ ]  No |
| **Endorsements** |
| SEF 71, OEF 71, QEF 71 – Excluding Owned Automobiles |       | [ ]  Yes [ ]  No |
| SEF 77, OEF 77 – Liability for Comprehensive Damage to Customers’ Automobiles (including open lot theft) |       | [ ]  Yes [ ]  No |
| Cross Liability |       | [ ]  Yes [ ]  No |
| Cancellation – 90 Days Notice |       | [ ]  Yes [ ]  No |

**Garage Loss History Detailed : From       To**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Cause / Description** | **Net Amt. Paid** | **Ded.****Amount** | **AdjustExpenses** | **Outstanding** | **Gross Total** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Criminal Legal Defence

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |

Coverage for allegations, claims or suits alleging criminal conduct for employees, board member, foster parents, teachers, volunteers, counselors with limits up to $100,000. Each insured person has access to lawyers who have expertise in the matters covered by the policy and the legal fees and disbursements are paid directly to the lawyer by the insurer.

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Legal Expense Insurance Coverage  | 200,000 | [ ]  Yes [ ]  No |
| Employment Disputes | 200,000 | [ ]  Yes [ ]  No |
| Legal Defence | 200,000 | [ ]  Yes [ ]  No |
| Bodily Injury | 200,000 | [ ]  Yes [ ]  No |
| Statutory Licence Protection | 200,000 | [ ]  Yes [ ]  No |
| tax Protection | 250,000 | [ ]  Yes [ ]  No |
| Contract Disputes & Debt Recovery | 200,000 | [ ]  Yes [ ]  No |
| Telephone Legal Advice Service | 200,000 | [ ]  Yes [ ]  No |
| Deductable |
| Wrongful Act | 2,500 | [ ]  Yes [ ]  No |

Accidental Death & Dismemberment

|  |  |
| --- | --- |
| [ ]  Quotation [ ]  New Business [ ]  Renewed [ ]  Replacing Policy No.  |       |

To provide benefits to Insured Persons in the event of an accident that results in the bodily injury, dismemberment or death.

|  |  |
| --- | --- |
| Insured |       |

|  |  |
| --- | --- |
| **Limit of Coverage Options** | **Coverage provided** |
| Class 1 (a) | Chiefs, Council Members, Board Members, Trustees, Directors | 200,000 Principal Sum |
| Class 1 (b) | Police and Security Guards | 200,000 Principal Sum |
| Class 1 (c) | Firefighters | 200,000 Principal Sum |
| Class 1 (d) | Teachers | 200,000 Principal Sum |
| Class 2 (a) | Volunteers | 50,000 Principal Sum |
| Class 2 (b) | Part-time employees and Full-time Employees NOT included in Class 1 | 50,000 Principal Sum |
| Class 3 | Spouse or Dependent Child of all Class 1 insured persons | 10,000 Principal Sum |
| Class 4 | Children attending Day-Care Centres or Educational Centres over six (6) months and under eighteen (18) years of age | 20,000 Principal Sum |

Premium is based on all insured under the age of 70 years old.

Claims History

**Summary by Policy Year: From       To**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Policy Year** | **Net Amount Paid (# Claims)** | **Adj. Expenses** | **Outstanding** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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Ventures Schedule of Values

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| --- | --- | --- | --- |
| Occupancy (Usage) |  | Building Value |  |
| Other Contents |  | Equipment |  |
| Stock |  | Business Interest |  |
| Rents Value |  | Year Built |  |
| Area (Square Feet) |  | Number of Stories |  |
| Floor |  | Roof |  |
| Roof Covering |  | Nearest Fire Dept. |  |
| Fire Hydrants (Distance) |  | Fire Alarm Type |  |
| Extinguishing System |  | Extinguishing Agent |  |
| Electrical |  | Plumbing |  |
| Heating |  | Fuel |  |

Ventures Auto Schedule

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Model** | **VIN** | **Value** | **Use** | **Class** | **RIN#** | **Registered To** |
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Declaration

The Proposer declares and warrants that after full and reasonable enquiry and investigation and to the best of his/her knowledge and belief all statements and particulars contained in this Proposal Form and (if applicable) any addenda hereto are true and that no information whatsoever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal Form and that should the above particulars alter in any way confirms that he/she will advise the Underwriters as soon as is practicable.

The Proposer further declares and warrants that he/she has been duly authorized by the Directors and Officers and the Company to act as their agent in respect of all matters of any nature or kind relating to or affecting this Proposal Form and the Policy.

The Proposer understands that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal Form may result in the Underwriters refusing to provide indemnity or voiding the Policy in every respect.

The Proposer hereby agrees and accepts that this Proposal Form and (if applicable) addenda hereto shall be the basis of the contract of insurance if entered into.

he Underwriters are hereby authorized, at their absolute discretion, to make any investigation and enquiry in connection with regard to this Proposal Form as they deem necessary.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |
|  |  |  |
| Name of Signatory |  | Position |
|  |  |  |
| Contact Person |  | Telephone # |

**Attached Documents**

* Exposure Data
* Schedule of Locations and Values
* Claims History
* Risk Control
* Policy Wording
* Claims Administration
* Other Supporting Documents