CAPITOL INDEMNITY CORPORATION | A Stock Company
P. O. Box 5900 | Madison, WI 53705-0900 | CapSpecialty.com

HUMAN SERVICES PROFESSIONAL LIABILITY APPLICATION

INSTRUCTIONS

- ***Answer ALL questions completely, leaving no blanks. If any questions, or any part thereof, do not apply, print "N/A" in the appropriate space.***
- ***This Application must be completed and signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application.***

SUPPORTING DOCUMENTATION REQUIRED

Along with this completed and signed application, the applicant must also submit the following:

- Five (5) years of loss information. (For losses exceeding $50,000 in value or involving loss of life, physical or sexual abuse or professional liability, please attach a detailed description of each loss/incident and describe corrective measures taken or lessons learned.)
- Provide copies of any descriptive brochure or narrative describing operations or website.
- Financial Statements— if organization is a for-profit entity.
- Completed and signed Supplemental Applications.
- Statements of Value (for property schedules), if property coverage is requested.
- If general liability, auto coverage or property coverage is requested; Acord Applications must be submitted.

I. GENERAL APPLICANT INFORMATION

1.1	First Named Insured:	☐ For-Profit	☐ Not-For-Profit
	DBA:	Website:	
	Address:	Phone Number:	
	City, State, Zip:	County:	
1.2	Risk Management Contact Name*: *Please note that this person may be contacted about Risk Management Services offered by or through the Insurer.	Title:	
	Email Address:	Phone Number:	
1.3	Year Established: ***If less than three (3) years in business, attach a copy of director's resume.***	Years Under Current Management:	
1.4	Accreditation(s): ☐ JCAHO ☐ CARF ☐ COA ☐ Other, describe:		
	Professional Organization memberships or affiliations:		
1.5	Name of Applicant's Executive Director/Manager?	Number of Years of Management Experience: Number of Years Managing Applicant Facility:	
1.6	Describe Applicant's operations and types of clients served (attach brochure(s) if available):		
1.7	Types of services offered by Applicant (please check all that apply): ☐ Residential Treatment ☐ Outpatient Treatment ☐ In-Home Services ☐ Independent Living ☐ Day Program ☐ Foster Care ☐ Adoptions ☐ Other, describe:		
1.8	Total number of staff (including office, janitorial, maintenance, etc.): Full Time Part Time		
1.9	Does Applicant and all healthcare providers employed by and contracted by Applicant have all required licenses?	☐ Yes ☐ No	☐ N/A
1.10	Has Applicant's or any healthcare provider's license ever been revoked or suspended, or is any license proceeding pending that could result in revocation or suspension?	☐ Yes ☐ No	☐ N/A
	If yes, please explain:		
1.11	Has Applicant ever been investigated, audited or inspected by any governmental agency, insurance company or independent inspection firm?	☐ Yes ☐ No	
	If yes, please provide details in an attachment, and a copy of the inspection report or other pertinent documentation. Include any deficiencies found, and corrective actions taken.		
1.12	Have there ever been any suits, legal proceedings or other claims against Applicant or any healthcare provider of Applicant that allege professional negligence or failure to comply with any regulatory or licensing standards or guidelines?	☐ Yes ☐ No	
1.13	Have there ever been any complaints filed against Applicant or any healthcare provider of Applicant with any regulatory or licensing body?	☐ Yes ☐ No	
	If yes to *1.12* or *1.13*, please provide details in an attachment.		
1.14	Has Applicant discontinued any operations or sold any operations in the last five (5) years?	☐ Yes ☐ No	
	If yes, please explain:		
1.15	Has Applicant acquired any operations or entities in the last five (5) years?	☐ Yes ☐ No	
	If yes, please provide details in an attachment.		
1.16	Does Applicant act as a managed care organization or gatekeeper? For the above, a "gatekeeper" means an individual or entity which is responsible for managing a patient's treatment, and thus refers the patient to doctors and specialists (usually within a plan network).	☐ Yes ☐ No	
1.17	Does Applicant lease or rent any properties or office space to third parties?	☐ Yes ☐ No	
	If yes, does Applicant obtain certificates of insurance from such parties evidencing General Liability coverage and Property coverage for such property or space?	☐ Yes ☐ No	
1.18	Does Applicant have any plans for renovations or new construction at its business facilities in the next 12 months?	☐ Yes ☐ No	
	If yes, please explain:		

II. CLIENT PROFILE

2.1	What is the total number of clients served annually?	
2.2	Please provide the percentage of Applicant's total clients served annually at each age range listed below (total must equal 100%): Children (1-12 years): % Teenagers (13-17): % Adults (18-64): % Senior (65+): %	
2.3	What is the total number of 65+ developmentally disabled clients served annually?	
2.4	What is the total number of non-ambulatory clients served annually?	
2.5	What is the total number of clients with Alzheimer's and Dementia annually?	
2.6	What is the total number of medically fragile clients served annually?	
2.7	Does the Applicant provide any programs for, or services to, sexual offenders?	☐ Yes ☐ No
	If yes, please explain:	
2.8	Does the Applicant provide any services to ex-offenders (an offender released from prison) or incarcerated individuals?	☐ Yes ☐ No
	If yes, please explain:	

III. REVENUE INFORMATION

3.1	Fiscal Year End Date:	Annual Revenue: $	Annual Payroll: $	
3.2	Does Applicant sell any goods, products or services to third parties? (If yes, please fill in details below)			☐ Yes ☐ No
	Goods/Products:	Annual Receipts: $	Description:	
	Services:	Annual Payroll: $	Description:	

IV. CURRENT / PRIOR COVERAGE

Please provide the requested information below for Applicant's current insurance coverage.

4.1	**Current Coverage Type(s)**	**Per Occ. / Per Claim Limit**	**Aggregate Limit**	**Retroactive Date**	**Claims-Made?**	**Current Annual Premium**
	Professional Liability	$	$		☐	$
	General Liability	$	$		☐	$
	Abuse & Molestation Liability	$	$		☐	$
	Employee Benefits Liability	$	$		☐	$

4.2	Is any Extended Reporting Period currently in force?	☐ Yes ☐ No
	If yes, indicate the coverage it applies to, and provide the duration and expiration date of the extended reporting period:	
4.3	Has Applicant ever applied for Professional Liability Insurance or any similar type of insurance coverage and been denied, cancelled or non-renewed? (**NOT APPLICABLE TO MISSOURI APPLICANTS.**)	☐ Yes ☐ No
4.4	Is Applicant aware of ANY claims, suits, proceedings, investigations, complaints or allegations of negligence or misconduct (including those of abuse or molestation) made against Applicant organization, or against anyone working on Applicant's behalf, brought or made against any proposed insured in the past five (5) years?	☐ Yes ☐ No
	If yes, please provide details in an attachment, including dates, current status, amount paid/incurred, and resulting organizational/policy changes implemented as a result.	

V. OPERATION SAFETY PRACTICES

5.1	Does Applicant have sign-in / sign-out procedures for: ☐ Staff ☐ Clients ☐ Visitors/Public	
5.2	Type(s) of security provided for clients: ☐ Guards ☐ Cameras ☐ Other:	
5.3	Does Applicant have a committee in place that reviews and investigates all incident reports to determine whether any action, including correction action, should be taken?	☐ Yes ☐ No
5.4	Does Applicant have an enterprise-wide media plan in place for emergencies?	☐ Yes ☐ No
5.5	Does Applicant have a plan for medical emergencies?	☐ Yes ☐ No
5.6	Is there always someone on premises who is trained in CPR and First Aid?	☐ Yes ☐ No
5.7	Does Applicant have a written and enforced "No Smoking" policy?	☐ Yes ☐ No
5.8	What method(s) does Applicant's staff use for de-escalation?	
	a. Are all staff members trained and certified in the use of such methods?	☐ Yes ☐ No
	b. How often is the staff trained and re-certified?	
5.9	Does Applicant's staff use restraint methods in Applicant's operations?	☐ Yes ☐ No
	If yes, please select all restraint types that apply: ☐ Physical ☐ Mechanical ☐ Chemical ☐ Other, describe:	
5.10	Does Applicant organization provide accident insurance for clients?	☐ Yes ☐ No
	If yes, please provide additional information below: Insurance Company Name: Limits of Liability: Accident Insurance: ☐ Applies to all clients ☐ Optional, at client's expense	

VI. PROFESSIONAL LIABILITY

6.1	Does Applicant require staff (paid and volunteer) to complete an employment application?	☐ Yes ☐ No
6.2	Does Applicant conduct a personal interview for each prospective staff member?	☐ Yes ☐ No
6.3	Does Applicant verify employment-related references?	☐ Yes ☐ No
6.4	Does Applicant verify licenses and other credentials for professional staff?	☐ Yes ☐ No
6.5	Does Applicant obtain a criminal background check on all staff members (paid and volunteer) prior to hiring?	☐ Yes ☐ No
	If yes, are negative findings considered in the decision to employ?	☐ Yes ☐ No
6.6	Does Applicant require drug tests on all staff members, including drivers?	☐ Yes ☐ No
	If yes, check all that apply: ☐ Before Hiring ☐ After Hiring ☐ Random What actions does Applicant take, if any, if these reports are unfavorable?	
6.8	Are files maintained in a manner to protect the confidentiality of clients and HIPAA compliant?	☐ Yes ☐ No
6.9	Does Applicant utilize volunteer workers?	☐ Yes ☐ No
	If yes, what are their duties? ☐ Clerical ☐ Driving ☐ Fundraising ☐ Work with Clients ☐ Other:	
6.10	Are any volunteers completing any court-mandated community service?	☐ Yes ☐ No ☐ N/A
	If yes, please provide complete description of service:	
6.11	Does Applicant provide or utilize telemedicine or telehealth services (not including telepsychiatry)?	☐ Yes ☐ No
	a. What percent of Applicant's total operations? % b. Please provide complete description of the services provided:	
6.12	Does Applicant operate any free or federally-funded public health clinic?	☐ Yes ☐ No
	If yes, do all such clinics qualify for FTCA (Federal Tort Claims Act) Program Coverage?	☐ Yes ☐ No
6.13	Does Applicant operate a crisis hotline?	☐ Yes ☐ No
	a. What is the estimated annual number of calls received? b. Estimated percentage by type of calls: Child/Spouse Abuse: % Drug/Alcohol: % Teen/Young Adult: % Suicide: % Other, : % c. Do volunteers answer calls for the crisis hotline?	☐ Yes ☐ No
6.14	Does Applicant's program include involuntary treatment (other than alcohol related traffic offenders)?	☐ Yes ☐ No
	If yes, what percent of Applicant's overall operations? %	
6.15	Does Applicant dispense medications?	☐ Yes ☐ No
	a. Are all medications stored under lock and key? If no, please explain: b. Which staff members have the authority to dispense medications?	☐ Yes ☐ No
	c. Are over-the-counter medicines dispensed to clients without written permission from a physician?	☐ Yes ☐ No
	d. Does Applicant maintain a written or electronic medication log for each client?	☐ Yes ☐ No
6.16	Are contracted professionals used by Applicant?	☐ Yes ☐ No
	a. Does Applicant require them to sign a Hold Harmless or Indemnification agreement in favor of Applicant?	☐ Yes ☐ No
	b. Are Certificates of Insurance evidencing professional liability coverage required and kept on file for those contracted professionals?	☐ Yes ☐ No
	If yes, what are the minimum limits that are required? $ Each Claim $ Aggregate	

VII. PROFESSIONAL STAFF

7.1 Please complete the schedule below for all Physicians and Psychiatrists contracted or employed by Applicant. If necessary, provide information in a separate attachment:

	Physician #1	**Physician #2**	**Physician #3**	**Physician #4**
Name of Physician:				
Specialty:				
Employed or Contracted:	☐ Employed ☐ Contracted	☐ Employed ☐ Contracted	☐ Employed ☐ Contracted	☐ Employed ☐ Contracted
DEA License:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Years in Practice:				
Average Number of Hours working per week for Applicant:				
Board Certified:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does Physician carry his/her own medical malpractice insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, does it provide coverage for his/her conduct while providing services for or on behalf of Applicant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have any claims, suits, proceedings or investigations related to this Physician been brought in the past five (5) years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7.2 Please complete the schedule below indicating the number of all staff. Do not include the staff already listed in question *7.1* above.

Position	Number of Employees		Number of Contractors		Number of Volunteers		Number of Interns	
	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time
Case Manager/Counselor:								
Child Care Worker:								
Chiropractor:								
Clergy:								
Clerical/Office Staff:								
CNA:								
Dental Assistant:								
Dental Hygienist:								
Dentist:								
Direct Support Professional:								
Medical Director (Admin Only):								
Medical Technician:								
Nurse Practitioner:								
Nurse - RN, LPN:								
Nutritionist/Dietician:								
Optometrist:								
Pharmacist:								
Pharmacy Assistant/Tech:								
Physician:								
Physician Assistant:								
Psychiatrist:								
Psychologist:								
Residential Manager:								
Social Worker:								
Teacher:								
Therapist - Occupational:								
Therapist - Physical:								
Therapist - Recreational:								
Therapist - Respiratory:								
Therapist - Speech:								
Other, specify:								
Other, specify:								

VIII. ABUSE AND MOLESTATION ☐ N/A

8.1 Does Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex-related offense, before an offer of employment is made? ☐ Yes ☐ No

8.2 Is there a written supervision plan that monitors staff in day-to-day relationships with clients both on and off premises? ☐ Yes ☐ No

8.3 Has Applicant organization ever had an incident which resulted in an allegation of sexual abuse or molestation? ☐ Yes ☐ No

a. Please describe incident:
b. What procedures where put in place to prevent future reoccurrence?

8.4 Does Applicant have a written crisis management plan in place for dealing with employees, victims, parents and the media if there is an incident of abuse? ☐ Yes ☐ No

8.5 Does Applicant have procedures in place to make sure no relationship occurs between staff and clients? ☐ Yes ☐ No

8.6 Are there written procedures and documented training for staff and volunteers on recognizing the signs of physical, sexual and emotional abuse? ☐ Yes ☐ No

8.7 Does Applicant have procedures in place to avoid one-on-one situations, so that more than one employee or volunteer is present at all times when a child is in your care? ☐ Yes ☐ No ☐ N/A

8.8 Is there more than one person responsible for the welfare of any single client? ☐ Yes ☐ No

8.9 Is off-site mentoring of clients by staff allowed by the Applicant? ☐ Yes ☐ No

Is it allowed on a one-on one basis? ☐ Yes ☐ No

8.10 Have any of Applicants current or former employees been the subject of a child abuse/neglect investigation? ☐ Yes ☐ No

If yes, what were the results of the investigation?

8.11 Does Applicant run criminal background checks, prior to employment or volunteering, on all: Employees: ☐ Yes ☐ No
Volunteers: ☐ Yes ☐ No ☐ N/A

IX. AUTOMOBILES ☐ N/A

9.1	Are all vehicles listed on the ACORD Application submitted by Applicant titled and registered to the Applicant organization?	☐ Yes ☐ No
	If no, please explain:	
9.2	Where does Applicant keep its owned vehicles? (check all that apply): ☐ Garage ☐ Driveway ☐ Parking Lot ☐ Employee Homes ☐ Other:	
9.3	Are keys always locked and secured away from clients when not in use?	☐ Yes ☐ No
9.4	Do vehicles with capacity for eight (8) or more passengers have an audible back-up warning?	☐ Yes ☐ No ☐ N/A
9.5	Are vehicles checked upon arrival and departure after passengers exit to make sure nobody is left behind?	☐ Yes ☐ No
9.6	Does Applicant transport passengers for any third party, including any other human services agency?	☐ Yes ☐ No
	If yes, please explain:	
9.7	Are clients ever permitted to drive Applicant's vehicles?	☐ Yes ☐ No
9.8	Does Applicant allow staff personal use of its' vehicles?	☐ Yes ☐ No
9.9	Does Applicant require seat belts to be worn by all occupants?	☐ Yes ☐ No
9.10	Does Applicant have a vehicle maintenance program in place?	☐ Yes ☐ No
9.11	Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passenger?	☐ Yes ☐ No ☐ N/A
9.12	Does Applicant transport clients?	☐ Yes ☐ No
	a. Is training provided for new employees and volunteers prior to them transporting clients?	☐ Yes ☐ No
	b. While transporting more than five (5) clients, are at least two (2) employees required to be present?	☐ Yes ☐ No ☐ N/A
9.13	Does Applicant accept donations of vehicles of any type?	☐ Yes ☐ No
9.14	Does Applicant have or utilize 15 passenger vans?	☐ Yes ☐ No
	If yes, please complete the following:	
	a. Are Applicant's 15 passenger vans equipped with Electronic Stability Control?	☐ Yes ☐ No
	b. Is there a pre-trip inspection of the vehicle?	☐ Yes ☐ No
	If yes, does this include a tire pressure check?	☐ Yes ☐ No
	If no, describe frequency of inspections, tire pressure checks and use of van(s):	
	c. Are all drivers of 15 passenger vans experienced and trained in the use of this type of van?	☐ Yes ☐ No
	If no, select all that apply: ☐ Limit passengers to 10 or less ☐ Remove rear seat ☐ Cargo is never loaded on roof	

X. DRIVERS ☐ N/A

10.1	Does Applicant obtain a written authorization to release driver information from each staff member upon hiring?	☐ Yes ☐ No
10.2	Does Applicant obtain Motor Vehicle Records (MVRs) on all drivers?	☐ Yes ☐ No
	If yes, how often? (select all that apply): ☐ Pre-hire ☐ Annually ☐ Other:	
10.3	Does Applicant have written criteria for acceptable / unacceptable MVRs?	☐ Yes ☐ No
10.4	Does Applicant require that its drivers have at least three (3) years driving experience before being allowed to transport clients in Applicant's vehicles?	☐ Yes ☐ No
10.5	Does Applicant have drivers with more than two (2) moving violations in the past three (3) years?	☐ Yes ☐ No
10.6	Does Applicant have any drivers with any major motor vehicle violations?	☐ Yes ☐ No
10.7	Does Applicant have a driver safety program?	☐ Yes ☐ No

XI. HIRED AND NON-OWNED AUTOS ☐ N/A

11.1	Are any of the vehicles used in Applicant's business operations rented, leased or hired by Applicant?	☐ Yes ☐ No
	If yes, indicate in attachment how many vehicles total, and for each vehicle describe what type, what uses and how often used.	
11.2	Does Applicant hire any autos from a transportation company?	☐ Yes ☐ No
	a. With drivers?	☐ Yes ☐ No
	b. Annual cost of hire: $	
11.3	Do Applicant's staff members, employees or volunteers drive their own personal vehicles while performing services or duties for, or on behalf of, Applicant?	☐ Yes ☐ No
	a. Number of staff members/employees driving regularly:	
	b. Number of volunteers driving regularly:	
	c. Are MVRs checked annually?	☐ Yes ☐ No
	d. Does Applicant require proof of personal auto insurance from the employee or volunteer?	☐ Yes ☐ No
	e. Are state statutory limits required?	☐ Yes ☐ No
11.4	Is an inspection of employees' or volunteers' vehicles completed prior to allowing business use, to ensure the vehicles are safe and operational?	☐ Yes ☐ No

XII. RESIDENTIAL FACILITIES ☐ N/A

12.1 Please fill in the number of beds available for the following operations of Applicant:

Developmentally Disabled		Substance Abuse		Shelter/Low Income		Mental Health		Youth	
Group Home:		Detox:		Abuse Victims:		Inpatient Crisis:		Group Home:	
Intermediate Care Facility:		Sober Living Home:		Homeless:		Mental Health Facility:		Youth Crisis:	

	Supported Living:		Substance Abuse Facility:		Low Income Housing:		Supported Living:	
	Other, describe:				**Other, describe:**			
	Total number of residential beds: 0							

12.2	How many of Applicant's locations are residential facilities?	
12.3	How many of Applicants facilities provide overnight care for clients?	
12.4	What is the average length of stay in a residential facility for Applicant's clients?	
12.5	Are male residents segregated from female residents, other than family members?	☐ Yes ☐ No
	If yes, describe how they are separated:	
12.6	Are there any non-ambulatory residents at any residential location?	☐ Yes ☐ No
	If yes, are their living quarters situated on the ground level? If not on ground level, please explain:	☐ Yes ☐ No
12.7	Is the Applicant or any individual staff member appointed as the legal guardian or conservator for any of Applicant's residents?	☐ Yes ☐ No
	If yes, for what percent of residents? %	
12.8	Does a physician screen each potential resident prior to admission?	☐ Yes ☐ No
12.9	Are bathing facilities equipped with grab bars, non-slip surfaces and water temperature control devices?	☐ Yes ☐ No
	If yes, is the water temperature set at 100 degrees maximum?	☐ Yes ☐ No
12.10	Does Applicant's fire alarm system meet all applicable local, state or federal building code requirements?	☐ Yes ☐ No
12.11	Please indicate location(s) of smoke detectors in Applicant's residential facilities: ☐ None ☐ Each Resident's Room ☐ Common Areas ☐ Corridors ☐ Nursing Stations ☐ Kitchen/Dining Areas	
12.12	Please select type of smoke detectors in Applicant's residential facilities: ☐ Hardwired ☐ Battery Operated	☐ N/A
12.13	Are fire drills conducted at each residential facility?	☐ Yes ☐ No
	How often? Are they documented?	☐ Yes ☐ No
12.14	Are all residents primarily responsible for their own basic personal care, including bathing, dressing, eating, and toileting?	☐ Yes ☐ No
	If no, please explain:	
12.15	Is 24-hour awake staff supervision provided at all residential facilities?	☐ Yes ☐ No
12.16	Does Applicant, at each facility, meet the state requirements for staff/client ratio at all times?	☐ Yes ☐ No
12.17	What is the ratio of staff to client at each facility during the day (list each facility and ratio below or in an attachment)? staff/ client	
12.18	What is the ratio of staff to client at each facility at night (list each facility and ratio below or in an attachment)? staff/ client	
12.19	Are client room inspections conducted?	☐ Yes ☐ No
	a. How often are rooms inspected?	
	b. Does Applicant have a checklist to follow?	☐ Yes ☐ No
	c. Does Applicant retain documentation of each inspection?	☐ Yes ☐ No
12.20	Does Applicant accept the following types of clients (please check all that apply)? ☐ Fire Starters ☐ Sexual Aggressors	

XIII. SUBSTANCE ABUSE PROGRAMS ☐ N/A

13.1	Does Applicant operate a Methadone Maintenance Treatment (MMT) program for opioid addiction?	☐ Yes ☐ No
13.2	Does Applicant operate any other Medication-Assisted Treatment (MAT) program for opioid addiction?	☐ Yes ☐ No
	a. Number of MMT or MAT clients treated annually: Number of clients with "take home" privileges: b. Does Applicant obtain a signed warranty from each MMT or MAT client that they will not operate a motor vehicle while being treated?	☐ Yes ☐ No
13.3	Does Applicant operate a detoxification unit?	☐ Yes ☐ No
	a. How many beds are dedicated for the detox unit? b. If clients are experiencing delirium tremens (DTs) or seizures, please indicate the action taken by Applicant: ☐ Treat them at unit ☐ Refer them to a Hospital c. Please indicate the type of detoxification: ☐ Medical ☐ Social ☐ Other:	
13.4	Does Applicant operate a sober living home?	☐ Yes ☐ No
	If yes, does Applicant perform drug and alcohol testing on clients at this facility?	☐ Yes ☐ No

XIV. BEHAVIORAL HEALTH PROGRAMS ☐ N/A

14.1	Does Applicant provide integrated behavioral health and primary medical care services?	☐ Yes ☐ No
14.2	Does Applicant's intake procedures include a risk assessment that identifies specific characteristics of the client for potential suicide?	☐ Yes ☐ No
14.3	Have any of Applicant's clients ever attempted or committed suicide?	☐ Yes ☐ No
	If yes, complete the following: Number of attempts: Number of suicides: Please provide detail on the above, i.e. circumstances involved and when occurred for each.	

14.4	Are written instructions and training provided to staff in order to:	
	a. Identify urgent client needs?	☐ Yes ☐ No
	b. Ensure a prompt response to emergency situations?	☐ Yes ☐ No
14.5	Does Applicant administer medications?	☐ Yes ☐ No
	a. Is a complete list of a client's medications provided at intake?	☐ Yes ☐ No
	b. If a client is transferred, is a complete medication list with instructions provided to the accepting facility?	☐ Yes ☐ No
	c. Upon discharge, is a current list of medications provided and explained to the individual, family and the individual's primary care provider?	☐ Yes ☐ No
14.6	Does Applicant's risk management program include instructions for medical record documentation?	☐ Yes ☐ No

XV. IN-HOME CARE (SERVICES PROVIDED IN CLIENT'S HOME) ☐ N/A

15.1	Please provide Applicant's annual payroll for staff (employees and independent contractors) providing in-home services: $	
15.2	Are any one-on-one in-home services provided to children without a parent/guardian present?	☐ Yes ☐ No
15.3	Does Applicant sell and/or rent medical equipment to clients?	☐ Yes ☐ No
	If yes, provide Applicant's annual receipts for: Sales: $ Rentals: $	
15.4	Does Applicant have documented procedures and methods in place to prevent theft of valuables from a clients' home?	☐ Yes ☐ No
15.5	Does Applicant have a Commercial Crime Bond that covers loss or theft of client valuables by staff?	☐ Yes ☐ No
15.6	Are all staff that provide in-home services CPR certified?	☐ Yes ☐ No
15.7	Are all home visits documented by staff?	☐ Yes ☐ No
	a. Is documentation periodically audited to ensure complete and detailed record-keeping?	☐ Yes ☐ No
	b. How is staff monitored?	

XVI. EQUINE THERAPY SERVICES ☐ N/A

Please provide copies of all waivers and release forms used in your program for clients, participants, volunteers, parents, etc.

16.1	Which of the following equine therapy services does Applicant offer? ☐ Therapeutic Riding ☐ Rehabilitative Riding ☐ Hippotherapy ☐ Psychotherapy ☐ Grooming ☐ Recreational Riding ☐ Vaulting ☐ Therapeutic Driving ☐ Competitions ☐ Other:	
16.2	Are there any other activities taking place in the ring/ riding area at the same time as Applicant's services?	☐ Yes ☐ No
16.3	Is Applicant's equestrian therapy program accredited?	☐ Yes ☐ No
	If yes, by whom? How many years accredited?	
16.4	Are liability waivers signed by all parents / guardians / capable adult clients?	☐ Yes ☐ No
16.5	Does Applicant follow the safety and riding standards of the North American Riding for the Handicapped Association, Inc (NARHA)?	☐ Yes ☐ No
	Are Applicant's equine therapy instructors NARHA certified?	☐ Yes ☐ No
16.6	Does Applicant fasten a child to any part of the saddle?	☐ Yes ☐ No
16.7	Does Applicant use side walkers?	☐ Yes ☐ No
	If yes, what is the ratio of staff to participants? Staff: / Participants:	
16.8	Are safety helmets mandatory for all participants while riding or being around horses?	☐ Yes ☐ No
16.9	Does Applicant give horseback riding lessons?	☐ Yes ☐ No
	If yes: What is the total number of riding lessons given annually? What is the average size of each group?	
16.10	What is the minimum age of riders?	
16.11	Provide the numbers of horses in Applicant's program: Owned: Leased: Non-owned:	
16.12	What is the minimum number of hours, months or years of training required, for a horse to be used in Applicant's program? hours OR months OR years	
16.13	Describe the equipment or props used in the program:	

XVII. POOLS, PONDS, AND LAKES ☐ N/A

17.1	Does the Applicant utilize any pool or other swimming or water facilities of any kind with clients? If yes, please answer the following questions:	☐ Yes ☐ No
17.2	Are the appropriate number of trained lifeguards on duty at all times when the pool or other water facility is open?	☐ Yes ☐ No
	If no, please explain:	
17.3	Are all lifeguards at the pool or other water facility certified?	☐ Yes ☐ No
17.4	Are all swimmers evaluated for ability prior to swimming?	☐ Yes ☐ No
17.5	Are all non-swimmers required to wear life preservers?	☐ Yes ☐ No
17.6	Are all staff members trained in the following? (Check all that apply) ☐ Water Safety ☐ CPR ☐ First Aid	
17.7	Does Applicant ever allow clients to swim in a pond or lake?	☐ Yes ☐ No
17.8	Does Applicant utilize a buddy system at the pool or other water facility?	☐ Yes ☐ No
IF APPLICANT'S UTILIZES SWIMMING POOLS IN ITS OPERATIONS, PLEASE ANSWER THE FOLLOWING QUESTIONS:		
17.9	Do posted pool rules meet all state and local regulations?	☐ Yes ☐ No
17.10	Are depths clearly marked?	☐ Yes ☐ No

17.11	Is the walking surface around the pool non-skid and in good condition?	☐ Yes ☐ No
17.12	Are all areas, including the bottom, visible at all times?	☐ Yes ☐ No
17.13	Who uses the pool area? ☐ Clients of Applicant ☐ Staff ☐ Unrestricted	
	If unrestricted, please explain:	
17.14	Is the pool completely fenced and gated?	☐ Yes ☐ No
	Is the gate self-locking?	☐ Yes ☐ No
	If yes, what height? Feet Inches	

XVIII. RECREATIONAL ACTIVITIES AND SPORTS ☐ N/A

Please provide copies of all waivers and release forms used in your program for clients, participants, volunteers, parents, etc.

18.1	Do clients of Applicant participate in any sports or recreational activities?	☐ Yes ☐ No
18.2	Do clients, while under Applicant's supervision, participate in any sports or recreational activities either:	
	a. On Applicant's business premises?	☐ Yes ☐ No
	b. At any offsite location(s)?	☐ Yes ☐ No
18.3	Does Applicant use third party vendors/contracted parties to conduct sports or recreational activities for its clients?	☐ Yes ☐ No
	a. Does Applicant obtain Certificates of Insurance from all vendors/contracted parties, evidencing General Liability insurance coverage?	☐ Yes ☐ No
	b. Does Applicant require that it be named as an Additional Insured on contracted party's insurance policy?	☐ Yes ☐ No
	c. Does Applicant require waiver of subrogation in contracted party's insurance policy wording, in favor of the insured?	☐ Yes ☐ No
18.4	Indicate if any of the following are utilized in Applicant's recreational activities: ☐ Archery ☐ Horses ☐ Canoe/Kayak/Sail ☐ High Ropes ☐ Obstacle Courses ☐ Water Skiing ☐ Guns ☐ Motor Boats ☐ Low Ropes ☐ Rock Climbing Walls ☐ Zip Lines ☐ Other:	
18.5	If Applicant's utilizes a Ropes Course or Rock Climbing Wall in its recreational activities:	
	a. Please indicate the following: Height (at highest point): Who built it? Date of last safety inspection:	
	b. Are participants required to wear appropriate safety gear?	☐ Yes ☐ No
	c. Was the course or wall built to Association for Challenge Course Technology (ACCT) Standards?	☐ Yes ☐ No
18.6	Does Applicant have procedures in place at all recreational activities to:	
	a. Identify and respond to urgent client needs?	☐ Yes ☐ No
	b. Ensure a prompt response to emergency situations?	☐ Yes ☐ No
18.7	What is the staff to client ratio when conducting recreational activities with clients? to	
IF APPLICANT OPERATES A CAMP, OR HAS ANY CAMP EXPOSURE, PLEASE ANSWER THE FOLLOWING QUESTIONS:		☐ N/A
18.8	Briefly describe the purposes/operations of the camp:	
18.9	Indicate average age of campers:	
18.10	What is the staff to camper ratio? to	
18.11	Does the camp ever provide overnight stays for campers?	☐ Yes ☐ No
	If yes, what is the average number of consecutive nights a camper stays at camp:	
18.12	What are the total number of days that the camp is operated, annually?	
18.13	What is the total number of camp participants, annually?	
18.14	Are sleeping areas separated by sex?	☐ Yes ☐ No
18.15	Are showering areas separated by sex?	☐ Yes ☐ No

XIX. ADOPTION AND FOSTER CARE - GENERAL INFORMATION ☐ N/A

19.1	Applicant organization is Accredited by or Certified by the following organizations (check all that apply): ☐ Council on Accreditation (COA) ☐ Applicable State Department of Human Services/Social Services ☐ Other:	
19.2	Services performed by Applicant: ☐ Adoption Services ☐ Foster Care Services	
19.3	Select all services listed below that are provided by Applicant and indicate percentage of Applicant's total services: (Total must be 100%.)	
Adoption	☐ Domestic Adoption Services: %	
	☐ International Adoption Services: %	
	☐ Other, : %	
Foster Care	☐ Foster Family Agency: %	
	☐ Treatment Foster Care: %	
	☐ Other, : %	

XX. ADOPTION SERVICES ☐ N/A

20.1 Is Applicant organization currently licensed to provide adoption services in all states in which it operates? ☐ Yes ☐ No
If yes, list states, state agency licensed by, and original date license was effective?

20.2 Have any of Applicant's licenses ever been suspended, revoked, or placed under conditional status by any state agency or other regulatory body? ☐ Yes ☐ No
If yes, please explain:

20.3 Have any complaints ever been made against Applicant organization, or any current or past staff members, regarding adoption services? ☐ Yes ☐ No
If yes, please explain:

20.4 Are Applicant's records inspected or audited by a state agency? ☐ Yes ☐ No
If yes: How often? By whom?

20.5 Is Applicant's facility inspected by a state agency? ☐ Yes ☐ No
If yes: How often? By whom?

20.6 If yes, to *20.4* or *20.5*, has applicant ever been cited or have there ever been negative findings as a result? ☐ Yes ☐ No
If yes, please explain:

20.7 Is Applicant a private or state-operated adoption organization? ☐ Private ☐ State-Operated

20.8 Is Applicant affiliated with any of the following organizations? ☐ Joint Council on International Children's Services (JCICS)
☐ North American Council on Adoptable Children (NACAC) ☐ National Council for Adoption (NCFA)

20.9 How are adoptive families evaluated by Applicant?

20.10 Does the evaluation process include an FBI and State criminal history background information check on prospective adoptive parents? ☐ Yes ☐ No

20.11 Does a Licensed Clinical Social Worker (LCSW) review all home studies? ☐ Yes ☐ No
If no, please explain:

20.12 Are prospective adoptive parents required to take adoption courses as part of pre-service training? ☐ Yes ☐ No
If yes, does training include information on reactive attachment disorder? ☐ Yes ☐ No

20.13 What is the average case load per social worker at any given time?

20.14 How many home studies were performed by Applicant for prospective adoptive parents in the last 12 months?

20.15 What specific information does Applicant typically disclose about a child for adoption to pre-adoptive parents prior to formalizing the adoption agreement? (Check all that apply)
☐ Medical/Health Information ☐ Birth Parent Family History ☐ Birth Parent Drug or Alcohol Abuse
☐ Prior Child Abuse or Neglect ☐ Prior Foster (or Other) Placements ☐ Institutionalization
☐ Prior Mental Health or Developmental Issues ☐ Any Trauma Experienced
☐ Other:

20.16 If the above listed or other material information about a child's history is unavailable, incomplete or lacking, does Applicant disclose this to the adoptive parents? ☐ Yes ☐ No

20.17 Does Applicant require adoptive parents to sign a waiver releasing Applicant organization of liability pertaining to information that is unavailable, incomplete or lacking? ☐ Yes ☐ No

20.18 Have the state court(s) where Applicant is licensed upheld the validity of waiver? ☐ Yes ☐ No
If no, please explain:

20.19 Has a child placed by Applicant ever died after placement? ☐ Yes ☐ No
If yes, please describe the circumstances pertaining to the death:

20.20 Does Applicant complete post-adoption reports, based on a recorded, post-adoption reporting schedule? ☐ Yes ☐ No
a. To whom do those reports get sent?
b. Are the reports based upon home visits? ☐ Yes ☐ No
c. Are the reports based on phone calls to adoptive parents? ☐ Yes ☐ No
d. Does a Social Worker complete the post-adoptive reporting? ☐ Yes ☐ No

20.21 What type(s) of post-adoption support and preservation services are provided to adoptive parents by Applicant?
☐ Counseling Services for Child ☐ Online or Classroom Courses or Training
☐ Counseling Services for Adoptive Parents ☐ Mental Health Services
☐ Resources on Understanding and Responding to Trauma ☐ Counseling and Support Services When Adoptive Parent is Relative
☐ Other (please list or describe all other services):

20.22 Have the adoptive parents of a child placed by Applicant organization ever been convicted of child abuse or neglect, with respect to the placed child? ☐ Yes ☐ No
If yes, please explain:

20.23 Has Applicant organization ever had any lawsuits filed against them? ☐ Yes ☐ No
a. Please describe the reason for the lawsuit:
b. What was the conclusion of the lawsuit?

20.24 Annual number of Adoptions Completed by Applicant for prior year and estimated total for current year:

Prior year:	Domestic Adoptions:	International Adoptions:	Embryonic Adoptions:	Failed Adoptions:
Current year:	Domestic Adoptions:	International Adoptions:	Embryonic Adoptions:	Failed Adoptions:

20.25	Failed Adoptions: a. Explain the reason(s) for the failed adoptions indicated above: b. What services are offered to adoptive parents and children to help avoid failure(s): What happens to the child in the event of a failed adoption?	
20.26	Does the Applicant review other alternatives to adoption with the birth parent(s)?	☐ Yes ☐ No
20.27	Medical Information:	
	a. Are children given a thorough medical examination, with prior conditions noted, before they are placed with the adoptive parents?	☐ Yes ☐ No
	b. If placement is of a newborn child, are hospital records given to the adoptive parents at time of placement?	☐ Yes ☐ No
	c. Are children given to adoptive parents upon release from hospital?	☐ Yes ☐ No
	d. Does Applicant perform genetic testing on children up for adoption?	☐ Yes ☐ No
	e. Does Applicant contract with a third party to perform genetic testing on children up for adoption?	☐ Yes ☐ No
20.28	Does Applicant actively comply with the applicable federal and state laws and regulations relating to mandated adoption procedures, disclosures and obtaining consent from parties?	☐ Yes ☐ No
20.29	Are children up for adoption through Applicant ever placed in a foster home temporarily?	☐ Yes ☐ No
20.30	With respect to adoptions made through Applicant, is there a time-period during which the birth mother or birth father may change their mind and revoke their consent to an adoption? (NOTE: State laws on this subject vary, so the specific amount of time, if any, will vary from state to state.)	☐ Yes ☐ No
	a. How long is the time-period (for each state in which you conduct adoptions)? b. Where is the child up for adoption placed, during this time-period? c. If the child is with their adoptive parents during this period of time, what is the procedure if either birth parent changes their mind during this time?	
20.31	With respect to the Birth Father: a. What is the procedure for locating and getting his consent? b. What is the procedure if unable to locate? c. How is the risk of not locating the birth father communicated to the adoptive parents?	
20.32	For placements made through Applicant, do the adoptive child's biological grandparents have any rights under applicable state laws with respect to the adoption placement?	☐ Yes ☐ No
	If yes, what rights do they have?	
20.33	Are birth parents counseled by Applicant to explore inter-family placement options (where a relative of the birth parent may adopt the child) prior to placement with others?	☐ Yes ☐ No
	If yes, is the process and results of that exploration communicated to the adoptive parents?	☐ Yes ☐ No
20.34	Counseling Services for birth parents:	
	a. Are Counseling Services provided to both the birth parents (if available) prior to an adoption placement?	☐ Yes ☐ No
	b. Are Counseling Services provided to both the birth parents (if available) after an adoption placement?	☐ Yes ☐ No
	c. Are other placement options explored with the birth parents during this counseling?	☐ Yes ☐ No

XXI. FOSTER CARE SERVICES ☐ N/A

21.1	Number of foster care placements made by/through Applicant: Last Year - Actual: This Year - Projected:
21.2	What is the total annual stipend amount paid to all foster care parents (for placements made by/through Applicant)? $
21.3	What is the average number of hours of training received by foster parents: Prior to placement: After Placement:
21.4	What is Applicant's average number of foster care caseworkers, per manager?
21.5	What is the minimum training required by Applicant for its foster care caseworkers? (Provide detail)
21.6	What is turnover rate, annually, of Applicant's caseworkers for foster care? %
21.7	Does Applicant contract with any municipality or municipal agency to provide foster care services? ☐ Yes ☐ No
	If yes, please explain and attach a copy of the contract(s).
21.8	How many foster families does Applicant use at any given time, on average?
21.9	What is the maximum number of foster children allowed per foster home by Applicant?
21.10	What is the number of total children (foster, adopted, natural) allowed per foster home?
21.11	What percentage of children placed by Applicant annually are moved at least one time, from one foster home to another? %
21.12	What is the percentage of children placed by Applicant annually, that have physical, developmental or mental disabilities? %
21.13	What is the percentage of children placed by Applicant annually, that are medically fragile? %
21.14	Does Applicant place children with the following disabilities? ☐ Severely Autistic ☐ Profound Mental Retardation ☐ Bedridden Due to Physical Disability
21.15	How does Applicant recruit foster parents?
21.16	Who compensates/reimburses the foster parents that Applicant works with?
21.17	How are the foster parents that Applicant works with evaluated, and by whom? (Please Explain):

21.18	What specific information does Applicant typically disclose about a child to the prospective foster parent(s) prior to placing that child with them? (Check all that apply) ☐ Medical/Health Information ☐ Family History ☐ Drug or Alcohol Abuse by child or parents ☐ Child Abuse or Neglect ☐ Prior Foster (or Other) Placements ☐ Institutionalization ☐ Mental Health or Developmental Issues ☐ Any Trauma Experienced ☐ Behavioral Issues ☐ Other, describe:
21.19	How often are foster home inspections performed once a placement is made?
21.20	Who performs such home inspections?
21.21	What percentage of all home inspections are: Scheduled: % Unscheduled: %
21.22	Does each home inspection include a separate consultation alone with the child? ☐ Yes ☐ No
21.23	Which services is the Applicant legally/contractually responsible for? (Check all that apply) ☐ Placement of children in homes ☐ Licensing of foster parents and homes ☐ Supervision and inspection of homes
	If Applicant contracts with a third party to provide any of the above services, please indicate which services and provide detail:
21.24	What steps are taken by Applicant in the event of an alleged physical or sexual abuse of a child placed in foster care?

XXII. CLAIMS AND INCIDENTS

Please respond to the following questions to the best of your knowledge and belief, after conducting due diligence and inquiry with any individuals who may have knowledge or information about the matters described below.
The term "Applicant" as used below, means any proposed insured, including any individual or entity for whom coverage is sought.

22.1	During the past five (5) years, has Applicant received notice of any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any proposed insured, relating to the coverage sought under the policy applied for?	☐ Yes ☐ No
22.2	During the past five (5) years, has Applicant, or any agent on its behalf, given written notice to any current or prior professional or general liability insurance carrier of: a. Any claim, suit, legal proceeding, or regulatory proceeding or investigation, or licensure action or investigation against or involving any proposed insured? b. Any facts, circumstances or situations, which might give rise to a claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any proposed insured?	☐ Yes ☐ No ☐ Yes ☐ No
22.3	Is Applicant aware of any facts, circumstances, situations, transactions, events, acts, errors or omissions which could reasonably be expected to give rise to a claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any proposed insured, relating to the coverage sought under the policy applied for?	☐ Yes ☐ No
22.4	During the past five (5) years, has any proposed insured had a professional license or certification suspended or revoked?	☐ Yes ☐ No

The policy applied for, if issued, will not insure: any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation disclosed, or which should have been disclosed, in response to the above; or any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation that arises from any fact, circumstance, situation, transaction, event, act, error or omission disclosed, or which should have been disclosed, in response to the above.

XXIII. FRAUD WARNINGS

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 and subjects that person to criminal and civil penalties.

- **(Not applicable in AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, VT, WA and WV).**

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

APPLICABLE IN CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN FL AND OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL only.

APPLICABLE IN KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN KY, NY, OH AND PA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

APPLICABLE IN ME, TN, VA AND WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

APPLICABLE IN NJ

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

APPLICABLE IN OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

APPLICABLE IN VT

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

XXIV. REPRESENTATIONS AND SIGNATURE

By signing this Application, the undersigned represents and agrees, on behalf of Applicant and all proposed insureds, to the following

a. ***After conducting due diligence, the statements and answers furnished to the Company in this Application are accurate and complete to the best of Applicant's knowledge;***
b. ***Those statements and answers furnished to the Company are representations Applicant makes on behalf of all proposed insureds;***
c. ***Those representations are a material inducement to the Company to provide a Quotation;***
d. ***If a policy is issued, the Company will have issued that policy in reliance upon those representations;***
e. ***If there is any material change in the Applicant's condition, activities or services, or in the statements or answers provided in this Application, that occurs or is discovered between the date this Application is signed and the effective date of any policy, if issued, Applicant agrees to immediately notify the Company in writing; and***
f. ***The Company reserves the right, upon receipt of such notice, to modify or withdraw any Quotation previously offered by the Company.***

As used above, the term "Company" refers to Capitol Indemnity Corporation.

NOTHING IN THIS APPLICATION SHOULD BE INTERPRETED TO MEAN THAT COVERAGE WILL BE OFFERED TO APPLICANT, OR THAT ANY PERSONS, EVENTS OR OTHER SPECIFICS REFERENCED IN QUESTIONS, OR ANSWERS TO QUESTIONS, WILL BE COVERED UNDER ANY POLICY BOUND OR ISSUED TO APPLICANT.

This Application must be signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application.

Signature of Authorized Representative of Applicant	**Title**
Type / Print Name	**Date**
E-mail Address of Authorized Representative	

This Section must be completed and signed by a Licensed Insurance Agent in the States of Iowa, Florida and any other states which require such signature.

Licensed Insurance Agent Signature	**Agency Name / Agency Code**
Type / Print Name	**Insurance Agent License Number**