SOCIAL SERVICES PROFESSIONAL LIABILITY COVERAGE FORM

**DECLARATIONS**

**Occurrence**

Policy No.: Renewal of:

Item 1. Named Insured and Address:

The Named Insured is:  Individual  Partnership  Joint Venture  Limited Liability Company

Organization (Other Than a Partnership or Joint Venture)  Trust

Item 2. Policy Period:

From: **//** To: **//**

(12:01A.M. Standard Time at the Address of the Named Insured shown above.)

Item 3. Limits of Insurance:

(a) Each Professional Incident Limit: **$**

(b) Professional Liability Aggregate Limit: **$**

Item 4. Designated Professional Services Covered Under This Policy:

Item 5. Premium: **$**

Item 6. Claims Notification:

99 High Street

Boston, Massachusetts 02110

Attn: Miscellaneous Professional Liability Claims Manager

(877) 638-4244

Item 7. Endorsements: As per Schedule attached to the Policy

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Representative or

Countersignature Where Required by Law