Name of Insurance Company to which Application is made (herein called the "insurer", "company", etc.):

Granite State Ins Co  Illinois National Ins Co  New Hampshire Ins Co

**\*Above is for Company Use Only**

NEW YORK HUMAN SERVICES **APPLICATION**

IMPORTANT: ALL OPERATIONS MUST BE DECLARED AND THE APPROPRIATE SECTION OF THE SUPPLEMENTAL APPLICATION COMPLETED WHERE APPLICABLE. THIS IS NOT A BINDER.

Are General & Professional Liability being requested on an Occurrence or Claims Made Basis? \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| If you are applying for **claims made** coverage, the following **Important Notice** applies:  **NOTICE: THIS IS A CLAIMS MADE POLICY.  THIS POLICY APPLIES ONLY TO  THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.** |

**INSTRUCTIONS:**

1. Please type or print clearly

2. Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.

3. If additional space is needed to answer any questions fully, use the comments section or attach a separate page.

4. This application must be completed, dated and signed by a principal of the business.

**I. General Information**

1. Applicant

2. Business Address

3. Applicant is

Profit

Non-profit

Governmental

4. Contact

5. Phone

6. Description of operations (Please attach brochure)

7. Years in Operation

8. What organizations or associations is the applicant a member of?

9. Is applicant accredited by any organizations? Identify:

10. Applicant is licensed by:

11. Date of your last survey

12. Any deficiencies found Yes

No

13. Annual budget

14. Primary funding source

**II. Locations**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Location | Address | Nature of Service  Provided | Interest | Number of  Stories |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |

**III. Types of Services**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services**  **Provided** | **# Clients** | **# Visits**  **Annually** | **# Beds** | **If Inpatient, average length of stay** |
| Mental Health  Counseling |  |  |  |  |
| Family  Counseling |  |  |  |  |
| Substance Abuse Counseling |  |  |  |  |
| Detox |  |  |  |  |
| Special  Schools |  |  |  |  |
| Head Start |  |  |  |  |
| Referral  Services |  |  |  |  |
| Respite Care |  |  |  |  |
| Adult Day Care |  |  |  |  |
| Employment  Training |  |  |  |  |
| Medical Clinic |  |  |  |  |
| Child Day Care |  |  |  |  |
| Crisis Hotline |  |  |  |  |
| Foster Care |  |  |  |  |
| Adoption |  |  |  |  |
| Electroshock |  |  |  |  |
| Aversion  Therapy |  |  |  |  |
| Rehabilitation |  |  |  |  |
| Hospice |  |  |  |  |
| Halfway House |  |  |  |  |
| Other  (describe) |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Describe population served:

2. Age Group:

3. Describe any recreational facilities or activities provided:

**IV. Staff**

Please indicate the number of staff in each of the following categories:

|  |  |  |
| --- | --- | --- |
| **Profession** | **Employed or Contracted** | **Full time or Part time** |
| Nurses, L.P.N. |  |  |
| Nurses, R.N. |  |  |
| Psychologists |  |  |
| Counselors |  |  |
| Social Workers |  |  |
| Administrators |  |  |
| Volunteers |  |  |
| Other (describe) |  |  |

**V. Physicians**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Specialty** | **Board Certified or Eligibile** | **Employed or Contracted** | **Hours per week** | **Does physician carry own insurance?** | **Limits** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

1. If physicians carry own insurance, do you obtain certificates of insurance?

Yes

No

2. Are physicians to be covered under this policy?

Yes

No

**VI. Risk Management**

1. Is there a formal written risk management program in place?

Yes

No

2. Are drugs prescribed or administered?

Yes

No

3. Where are medications stored?

4. Are complete records kept on all patients? Yes

No

5. Do you require signed release forms for release of patient records?

Yes

No

If no, explain:

6. Are owned vehicles used to transport clients?

Yes

No

7. Please indicate all of the procedures you use when hiring staff:

Check of educational background or residency program, when applicable

Check of previous employers: In writing By telephone

Check of personal references: In writing By telephone

Check on hospital privileges for physicians

Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities

Require information on any professional liability or work-related claim that has previously been made against the individual

Request information on any prior convictions

Perform criminal background check

8. Do you train staff in how to recognize child/sexual abuse and how to report suspected incidents?

Yes No

9. Have any allegations of abuse ever been made against the applicant?

Yes No

If yes, explain:

**VII. Loss History**

1. Has the company canceled, declined to renew or refused insurance?

**(MISSOURI APPLICANTS NEED NOT REPLY)**

Yes

No

If yes, explain:

2. Enter all claims or occurrences that may give rise to claims for the prior 5 years.

Check here if none .

|  |  |  |
| --- | --- | --- |
| **Date of Loss** | **Description of Incident/Claim** | **Amount Paid** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**VIII. Present Insurance Information**

1. Company

2. Limits

3. Deductible

4. Premium

5. Effective Dates

6. Occurrence or Claims Made

If Claims Made, what is retroactive date?

**IX. Coverage Desired**

General Liability and Professional Liability

1. Limits:

$100,000/$300,000

$500,000/$1,000,000

$1,000,000/$3,000,000 Other:

2. Deductible:

None

$2,500

$5,000

$10,000

$25,000 Other:

3. Effective Date:

4. Is umbrella coverage desired: Yes

No

Limits:

**X. Attachments**

Please include the following information with the completed application:

1. Previous insurance company loss runs for the past five years

2. Current audited financial statement

3. Brochures, pamphlets or other advertising material used by your organization

4. Copies of any inspection reports/surveys conducted by outside organizations within the past three years

5. Copies of any contracts for professional services provided to your organization or by your organization

FRAUD STATEMENTS

**NOTicE to applicants:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ALABAMA APPLICANTS**: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO COLORADO APPLICANTS**: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**NOTICE TO FLORIDA APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**NOTICE TO KANSAS APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIAL 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.

**NOTICE TO KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**NOTICE TO LOUISIANA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MAINE APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO MARYLAND APPLICANTS:** ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MINNESOTA APPLICANTS:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NOTICE TO NEW JERSEY APPLICANTS**: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO NEW YORK APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

**NOTICE TO OHIO APPLICANTS**: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

**NOTICE TO OREGON APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO PENNSYLVANIA APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**NOTicE to vermont applicants:** 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.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE ACCURATE, TRUE AND COMPLETE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

Signed                                                                                                          Date

                                                (**Applicant**)

Title                                                                     Organization

(must be signed by authorized officer)                                                                 (Organization’s Seal)

Attest

Agent/Producer

License Number

Address

*COMMENT SECTION*