



## Social Service Agency Application

**This section is FOR OFFICE USE ONLY – Please do not complete.**

Diamond State Ins. Co.       United National Ins. Co.       United National Cas. Inc. Co.       United National Spec. Ins. Co.

All questions must be completed to enable us to provide you with a quote. Please include any brochures or descriptive materials that may assist us in a better understanding of your agency.

### YOUR AGENCY

1. The precise name of your agency including any 'D/B/A's' \_\_\_\_\_  
\_\_\_\_\_

For Profit       Non-Profit       Other

2. Your mailing address: \_\_\_\_\_  
City and State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Effective Date of Coverage: \_\_\_\_\_ Webpage address: \_\_\_\_\_

Please provide the addresses of all locations owned/leased by the insured to be covered:

	<b>STREET ADDRESS</b>	<b>CITY AND STATE</b>	<b>ZIP CODE</b>	<b>OCCUPANCY/EXPOSURE</b>
(1)	_____	_____	_____	_____
(2)	_____	_____	_____	_____
(3)	_____	_____	_____	_____
(4)	_____	_____	_____	_____

3. Please provide a brief description of your operations.  
\_\_\_\_\_  
\_\_\_\_\_

4. How long has your agency been in operation? \_\_\_\_\_ What is your annual budget? \_\_\_\_\_

a. Name all subsidiary companies/locations and other operations within applicant's control.  
\_\_\_\_\_

b. Has applicant sold, acquired or discontinued any operations in the last 5 years? If yes, explain.  
\_\_\_\_\_  
\_\_\_\_\_

5. Please give a complete percentage breakdown of your funding sources (total to equal 100%).  
\_\_\_\_\_

6. Of what organizations or associations are you a member? (Please avoid use of acronyms)  
\_\_\_\_\_

7. Are you aware of any state, federal, local code or professional ethics violations by your agency or any of your employees?  Yes  No

8. a. Does your state permit you to do criminal background investigations on prospective employees/volunteers? .....  Yes  No
- b. If yes, do you routinely request and receive such background investigations? .....  Yes  No
- c. Do you verify employment related references? .....  Yes  No
- d. Do you verify educational requirements? .....  Yes  No
- e. Do you conduct a personal interview? .....  Yes  No
- f. Are licenses checked for employees/volunteers, when appropriate? .....  Yes  No
9. a. Do you discuss at staff orientation, physical and sexual abuse issues, how to recognize the signs and what to do if a client reports someone abused him/her? ....  Yes  No
- b. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients? .....  Yes  No
- c. Do you have a crisis management plan for dealing with staff, victim, parents, authorities and media if you have an incident of abuse? .....  Yes  No
- d. Have you ever had an incident that resulted in an allegation of sexual abuse? .....  Yes  No  
 If yes, was a claim ever made you against ?.....  Yes  No  
 (If yes, please give details on a separate sheet of paper including the date of the incident and any action taken by management to prevent from occurring again.)
10. If yes, was a claim ever made you against? .....  Yes  No  
 Describe training offered \_\_\_\_\_

**YOUR OPERATIONS**

11. PLEASE CHECK **YES or NO** TO THE SERVICE (S) BELOW THAT BEST DESCRIBE YOUR OPERATION.

- a. **RESIDENTIAL CARE**  
 Do you operate any Residential Facilities? .....  Yes  No  
**(If "Yes", please complete a Residential Facility Questionnaire APA-160 for each facility.)**

- b. **OUTPATIENT SERVICES**  
 Provide annual number of appointments for the following services (each client's visit should be counted as an appointment) Include location no.:

YES	NO		No. of Appts	Loc No.
<input type="checkbox"/>	<input type="checkbox"/>	Drug & Alcohol Treatment Individual	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug & Alcohol Classes (DUI/DWI)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling: Individual	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling: Group	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	MR Treatment Center	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy Center	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rehabilitation Agency	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Case Management (MH/MR/Comm. Support)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Training	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospice (outpatient)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Family Skills Training	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Independent Living Skills Training	_____	_____
				On site _____
				Loc No. _____
				Off site _____

c. Provide number of clients/children per day and number of days per year that facility operates and at what location:

YES	NO		No. per	No. of clients per year	No. of days	Loc
<input type="checkbox"/>	<input type="checkbox"/>	Before & After School Care	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headstart Program	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Well Child Day Care	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Camps for Mentally Ill or Developmentally Disabled	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Care for Mentally Ill or Dev. Dis.	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recreation Program	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Schools	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	*Agencies for Aging/Senior Citizens	_____	_____	_____	_____

\*If yes, please describe the service provided for Agencies for Aging/Senior Citizens

d.   Foster and/or Adoption Placement Agency Loc No. \_\_\_\_\_  
**(If "Yes", please complete attached Foster/Adoption Placement Supplement APA-161.)**

e.   Home Care Home Health Care Respite Care Loc # \_\_\_\_\_  
 Age Range of Clients (please enter the number of clients in each age group):  
 Level of Care: Developmentally Disabled 0-17 \_\_\_\_\_ 18-60 \_\_\_\_\_ 60+ \_\_\_\_\_  
 Mentally Impaired 0-17 \_\_\_\_\_ 18-60 \_\_\_\_\_ 60+ \_\_\_\_\_  
 Other \_\_\_\_\_  
 Please describe services provided \_\_\_\_\_

f.   Methadone Maintenance Clinic No. of Licensed Slots: \_\_\_\_\_ Loc No. \_\_\_\_\_

g.   Meals on Wheels No. of Meals Annually: \_\_\_\_\_ Loc No. \_\_\_\_\_

h.   Hotline Center No. of Calls Annually: \_\_\_\_\_ Loc No. \_\_\_\_\_

i.   Referral Agency No. of Referrals Annually: \_\_\_\_\_ Loc No. \_\_\_\_\_

j.   CASA  
 (Court Appointed Special Advocates) No. of Cases Assigned Annually: \_\_\_\_\_ Loc No. \_\_\_\_\_

k.   Mentorship No. of Matches: \_\_\_\_\_ Loc No. \_\_\_\_\_

Center based  Off-site based  How often do they meet? \_\_\_\_\_ Loc No. \_\_\_\_\_

l.   Advocacy Services No. of Clients Serviced: \_\_\_\_\_ Loc No. \_\_\_\_\_

m.   Other Services not described above Annual Client Contacts of Appointments: \_\_\_\_\_  
Loc No. \_\_\_\_\_  
Loc No. \_\_\_\_\_  
Loc No. \_\_\_\_\_

12. **STAFF**

	Employees		Non-Employees (Volunteers/Consultants)	
	No. Full Time	No. Part Time	No. Full Time	No. Part Time
RN'S/LPN's	_____	_____	_____	_____
Physicians Assts.	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
If any Psychologists, are you requesting primary or excess coverage?	_____			
Others (specify)	_____	_____	_____	_____
	_____	_____	_____	_____

13. **EMPLOYED OR CONTRACTED PHYSICIANS AND PSYCHIATRISTS**  
 Do you want coverage for employed or contracted Physicians and Psychiatrists? .....  Yes  No  
**(If Yes, complete the attached Physicians and Psychiatrist Liability Questionnaire APA-171**  
 If yes, have you verified the credentials of the Physician(s) and/or Psychiatrists(s)  
 that you are requesting coverage for? .....  
 If excess coverage is being requested, have you verified other insurance? .....  Yes  No
14. Do you provide any primary medical or skilled nursing services?.....  Yes  No  
 If yes, please explain.
15. Do you or any of your staff prescribe any medications? .....  Yes  No  
 If yes, please provide a list on a separate sheet of paper of the medications, who  
 prescribes them, for what purposes, and how they are secured.
16. Do you contract with any other facilities for additional beds? .....  Yes  No  
 If yes, please indicate the number or estimated number of beds and provide a copy of  
 copy of the contract.            No. of Beds
17. Does your agency recommend release, parole or incarceration of clients? .....  Yes  No  
 If yes, please explain on a separate sheet of paper.
18. Do you treat any sexual offenders? .....  Yes  No  
 If yes, please explain on a separate sheet of paper.
19. Do you service clients recently released from a lock-up facility? .....  Yes  No  
 Describe the nature of offenses on a separate sheet of paper.
20. Are you licensed by the state(s) in which you operate? .....  Yes  No  
 If No, is a license required? .....  Yes  No  
 (Please attach a copy of license and latest inspection)  
 If yes, is it renewed     annually     semi-annually     other  
 Has your license ever been suspended or revoked? .....  Yes  No  
 If yes, please give details. \_\_\_\_\_

**ADDITIONAL INSURED(S) (PROFESSIONAL LIABILITY)**

		Insurable Interest – Check box that applies		
Name:	_____	<input type="checkbox"/> Funding/Grant	<input type="checkbox"/> Contract/Services	<input type="checkbox"/> Other
Address:	_____			Describe: _____
Name:	_____	<input type="checkbox"/> Funding/Grant	<input type="checkbox"/> Contract/Services	<input type="checkbox"/> Other
Address:	_____			Describe: _____
Name:	_____	<input type="checkbox"/> Funding/Grant	<input type="checkbox"/> Contract/Services	<input type="checkbox"/> Other
Address:	_____			Describe: _____
Name:	_____	<input type="checkbox"/> Funding/Grant	<input type="checkbox"/> Contract/Services	<input type="checkbox"/> Other
Address:	_____			Describe: _____

**COMMERCIAL GENERAL LIABILITY**

21. Would you like to include Commercial General Liability coverage? .....  Yes  No  
 (If yes, please provide complete the following section and also attach a completed Acord General Liability Applications.)

LOCATION NO.	1	2	3	4
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq ft)				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>
Heat Sensors	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>
Smoke Detectors	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>
f. Fire Escapes or Exits	No.	No.	No.	No.
g. Year of Updates in Construction	Year: _____	Year: _____	Year: _____	Year: _____
Plumbing	Yes No	Yes No	Yes No	Yes No
Wiring	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>

22. Do you lease or sub-lease to others any portion of the locations listed above? .....  Yes  No  
 If yes, do you require that your tenant carry liability insurance for the occupancy? .....  Yes  No  
 If yes, how often do you make sure the coverage is maintained? \_\_\_\_\_
23. Are there any pools at any of your locations? .....  Yes  No  
 If yes, how many? \_\_\_\_\_ Loc # \_\_\_\_\_  
 Are there spas or hot tubs at any of your locations? .....  Yes  No  
 If yes, how many? \_\_\_\_\_ Loc # \_\_\_\_\_  
 If no, describe the uses: \_\_\_\_\_
24. Is any construction or carpentry work done for clients or other parties? .....  Yes  No  
**If Yes, please provide on a separate sheet, a detailed description of the work being performed.**
25. Will you be organizing or sponsoring any fundraising or special events during the next year .....  Yes  No  
 \$ \_\_\_\_\_  
 \$ \_\_\_\_\_
26. Do you participate in or supervise any sports activities for your clients? .....  Yes  No  
 If yes, please describe: \_\_\_\_\_

**COMMERCIAL PROPERTY**

27. Do you participate in or supervise any sports activities for your clients? .....  Yes  No  
**If Yes, please complete the following section and also attach a completed Acord Property Applications.**  
**Notes: Please Photocopy this Commercial Property Section and complete for additional locations.**  
 a. What is your total Building value for all locations? \_\_\_\_\_  
 b. What is your total Business Personal Property value \_\_\_\_\_
28. Is cooking allowed in each room? .....  Yes  No  
 29. Is there a central eating area? .....  Yes  No  
 30. Is there an adequate number of smoke detectors in public areas and in all living units and fire extinguishers located in easy accessible areas? .....  Yes  No  
 31. Do the smoke detectors and fire extinguishers have an annual maintenance and certification? .....  Yes  No  
 32. Are there electrical powered smoked detectors? .....  Yes  No  
 33. Is all wiring with circuit breakers? .....  Yes  No  
 If yes, please explain \_\_\_\_\_  
 34. Are any buildings vacant, unoccupied, under renovation or construction? .....  Yes  No  
 35. Are all buildings designed for present occupancy? .....  Yes  No  
 36. Are there any outstanding NFPA recommendations? .....  Yes  No  
 37. Do all exterior doors have dead bolts and windows with adequate locks? .....  Yes  No  
 38. Is this a non-smoking facility? .....  Yes  No  
 If no, where is the smoking area located? \_\_\_\_\_  
 If no, is there a designated area for smoking and where is this area located? .....  Yes  No  
 39. Is the premises clean, neat and well lit? .....  Yes  No  
 40. Are any of the buildings used for low income housing, refugee facility or retail outlet? .....  Yes  No

**NON-OWNED AUTO LIABILITY**

**(Please complete attached Non-Owned Auto Questionnaire APA-162.)**

**ACCIDENT AND HEALTH**

41. Would you like us to quote Accident Coverage for Volunteers? (you should include unpaid consultants and board members) .....  Yes  No  
 If yes, give the estimated total number of volunteer days for all locations to be insured (i.e. the average number of volunteers active per day x the number of days annually your agency operates): \_\_\_\_\_
42. Would you like us to quote Accident Coverage for your Non-Resident Clients while they are participating in your sanctioned and sponsored activities? .....  Yes  No

**YOUR MOST RECENT INSURANCE HISTORY**

LINE	COMPANY	LIMITS	PREMIUM	DED	EXPIRATION DATE	RETROACTIVE DATE
Professional Liability						
General Liability						
Excess and/or Umbrella						
Property/IM/ Crime						

43. If you have not purchased coverage before, please explain. \_\_\_\_\_
44. Is your expiring professional liability and/or general liability coverage on a claims made basis? .....  Yes  No  
 If yes, would you like us to include prior acts coverage? .....  Yes  No  
 If yes, please provide proof of uninterrupted claims made coverage since the retroactive date.
45. Has any carrier cancelled or refused coverage for your agency? .....  Yes  No  
**(THIS QUESTION DOES NOT APPLY TO APPLICANTS IN MISSOURI)**  
 If yes, please explain.

**CLAIM INFORMATION**

46. Have you had any claims and/or circumstances that have not been previously reported? .....  Yes  No  
**(THIS QUESTION DOES NOT APPLY TO APPLICANTS IN MISSOURI)**  
 If yes, please attach detailed claim information with the date of the loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.  
**Please attach 5 years loss history for all coverages requested.**
47. Please describe your procedures when reporting potential incidents to the proper authorities.
-

**PLEASE READ THE FOLLOWING CAREFULLY**

**VIRGINIA, TENNESSEE FRAUD STATEMENT**

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.

**ARIZONA FRAUD STATEMENT**

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**ARKANSAS FRAUD STATEMENT**

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.

**CALIFORNIA FRAUD STATEMENT**

For your protection, California law requires that you be made aware of the following: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO FRAUD STATEMENT**

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.

**DISTRICT OF COLUMBIA FRAUD STATEMENT**

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.

**IDAHO FRAUD STATEMENT**

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**INDIANA FRAUD STATEMENT**

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**KENTUCKY FRAUD STATEMENT**

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.

### **LOUISIANA FRAUD STATEMENT**

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.

### **MAINE FRAUD STATEMENT**

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.

### **MINNESOTA FRAUD STATEMENT**

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

### **NEW HAMPSHIRE FRAUD STATEMENT**

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.

### **NEW JERSEY FRAUD STATEMENT – APPLICATION**

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

### **NEW MEXICO FRAUD STATEMENT**

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 civil fines and criminal penalties.

### **OHIO FRAUD STATEMENT**

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.

### **OKLAHOMA FRAUD STATEMENT**

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.

### **OREGON FRAUD STATEMENT**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

### **PENNSYLVANIA FRAUD STATEMENT**

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.

### **VERMONT FRAUD STATEMENT**

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 may be guilty of a crime and may be subject to fines and confinement in prison.

**FRAUD STATEMENT (All other states)**

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.

**SIGNATURE AND AGREEMENTS**

(The following warranties do not apply to applicants in Virginia and West Virginia but signatures are still required)

The undersigned represents that all statements and answers to questions are true, complete and accurate and that there has been no suppression or misstatement of fact. The undersigned agrees that any policy issued will rely on the truth of the statements.

THE APPLICANT ACCEPTS NOTICE THAT HE/SHE IS REQUIRED TO PROVIDE WRITTEN NOTIFICATIONS TO THE COMPANY OF ANY CHANGES IN THE RESPONSES GIVEN TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE.

Except to such an extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED and reported to the company while the policy is in force and which arise from services performed on or after the Retroactive Date of the policy.

The undersigned authorized representative of the applicant declares that (1) the statements set forth herein are true, (2) if the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify NIPC of such changes, and NIPC may withdraw or modify any outstanding quotations and/or agreement to bind insurance.

Date Signed \_\_\_\_\_ Signature of Applicant \_\_\_\_\_  
Print Name and Title \_\_\_\_\_

This application form duly completed, together with any supplementary information must be signed in ink by the applicant.

(The following warranties do not apply to applicants in Virginia and West Virginia but signatures are still required.)

**THE PRODUCER REPRESENTS THAT ALL OF THE INSURANCE REQUIREMENTS OF THE APPLICANT'S HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH. THIS INCLUDES THE SURPLUS LINES FILING AND THE SUBMITTING OF THE SURPLUS LINES FEES AND TAXES. SURPLUS LINES FILING AND THE SUBMITTING OF THE SURPLUS LINES FEES AND TAXES. THIS IS APPLICABLE IN ALL STATES EXCEPT CA, WA, AK AND CO. WE CAN DO FILINGS FOR YOU IN THOSE STATES IF NEEDED.**

_____	_____	_____
Please Print Name	Signature of Producer submitting to NIPC	Date Signed
	<input type="checkbox"/> Retailer <input type="checkbox"/> Wholesaler	
Producing Agency submitting to NIPC:	_____	
Address:	_____	
	_____	
Telephone: (     ) ____	__-__	_____
SURPLUS LINES BROKER	_____	
SURPLUS LINES LICENSE NUMBER	_____	FEIN NUMBER (FLORIDA ONLY) _____

**Did you remember to?**

**If you are requesting Professional Liability coverage:**

- Complete the Professional Liability Section of this application

**If you are requesting General Liability coverage:**

- Complete an Acord General Liability Application
- Complete the General Liability Section of this application

**If you are requesting Property:**

- Complete an Acord Property Application
- Complete the Property Section of this application

**If you are requesting Non-Owned Auto coverage:**

- Complete the Non-Owned Auto Questionnaire

**If you requesting Accident and Health coverage for your Volunteers and Non-Resident Clients:**

- Complete an Accident and Health Section of this application

**General Reminders:**

- Did you complete each question in all applicable sections as we cannot offer a quote based on incomplete information?
- Did you sign and date all applications?
- Did you attach current loss runs?