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HUMAN SERVICES PROFESSIONAL LIABILITY RENEWAL APPLICATION

Renewal of Policy Number:	

THIS IS AN APPLICATION FOR THE RENEWAL OF THE INSUREDS PROFESSIONAL LIABILITY POLICY WITH THE INSURER SHOWN ABOVE.
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 Renewal Application must be completed and signed by an authorized partner, officer or other principal of the Named Insured shown in Question 1.1.***

SUPPORTING DOCUMENTATION REQUIRED
Along with this completed and signed Renewal Application, the Insured must also submit the following:

- Financial Statement(s) for last fiscal year.

I. GENERAL INFORMATION

1.1	First Named Insured:	
	DBA:	Website:
	Business 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:

II. CLIENTS/OPERATIONS/SERVICES

2.1	What was the total number of clients served by the Insured this past year?	
2.2	In the past year, have there been any changes to the type of clients the Insured provides services?	☐ Yes ☐ No
	If yes, please explain:	
2.3	In the past year:	
	a. Have there been any changes to the type of services the Insured provides?	☐ Yes ☐ No
	b. Has the Insured begun providing any new services?	☐ Yes ☐ No
	c. Has the Insured discontinued any services previously provided?	☐ Yes ☐ No
	If yes to any of the above, please explain:	
2.4	In the past year:	
	a. Have there been any changes to the Insured's business operations?	☐ Yes ☐ No
	b. Has the Insured begun any new business operations?	☐ Yes ☐ No
	c. Has the Insured discontinued any of its business operations?	☐ Yes ☐ No
	If yes to any of the above, please explain:	

III. REVENUE INFORMATION

3.1	Fiscal Year End Date:	Revenue – Past 12 Months: $	Payroll – Past 12 Months: $
3.2	Does the Insured currently 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 Receipts: $	Description:

IV. SAFETY PRACTICES

4.1	Have there been any changes in the past year to the Insured's security systems or safety procedures?	☐ Yes ☐ No
	If yes, please explain:	

V. PROFESSIONAL STAFF

5.1 Please complete the schedule below for all Physicians and Psychiatrists currently contracted or employed by Insured. 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
Number of Years in Practice:				
Average number of hours working per week for Insured:				
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 Insured?	☐ 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

5.2 Please complete the schedule below indicating the current number of all staff. Do not include the staff already listed in question 5.1 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:								

5.3 In the past year, have any of Insured's current or former employees been the subject of a child abuse/neglect investigation? ☐ Yes ☐ No

If yes, what were the results of the investigation?

VI. RESIDENTIAL FACILITIES ☐ N/A

6.1 In the past year, has the Insured opened any new residential facilities, or closed any residential facilities? ☐ Yes ☐ No

If yes, please explain:

6.2 In the next year, does the Insured plan to expand its residential facilities or increase the number of beds? ☐ Yes ☐ No

If yes, please explain:

6.3 Does Insured, at each facility, currently meet the state requirements for staff/client ratio at all times? ☐ Yes ☐ No

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

7.1 Please provide Insured's current annual payroll for staff (employees and independent contractors) providing in-home services: $

VIII. ADOPTION SERVICES AND FOSTER CARE ☐ N/A

8.1 Have there been any changes to the Insured organization's accreditations or certifications by the Council on Accreditation (COA), the applicable State Department of Human Services/Social Services, or other applicable organization? ☐ Yes ☐ No

8.2 Services currently performed by Insured: ☐ Adoption Services ☐ Foster Care Services

8.3 In the past year, have any of Insured's licenses to provide adoption services been suspended, revoked, or placed under conditional status by any state agency or other regulatory body? ☐ Yes ☐ No

If yes, please explain:

8.4 In the past year, have any complaints been made against Insured organization, or any current or past staff members, regarding adoption services? ☐ Yes ☐ No

If yes, please explain:

8.5 In the past year, has any child placed by Insured been seriously injured or died after placement? ☐ Yes ☐ No

If yes, please describe the circumstances:

8.6 Annual number of Adoptions Completed by Insured for the past year, and estimated total for the next year:

Past Year:	Domestic Adoptions:	International Adoptions:	Embryonic Adoptions:	Failed Adoptions:
Next Year:	Domestic Adoptions:	International Adoptions:	Embryonic Adoptions:	Failed Adoptions:

8.7 Failed Adoptions:

a. Explain the reason(s) for the failed adoptions this past year:
b. What services were offered to adoptive parents and children to help avoid failure(s):
c. What happened to the children involved in the failed adoptions?

8.8 Does the Insured review other alternatives to adoption with the birth parent(s)? ☐ Yes ☐ No

8.9 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 Insured perform genetic testing on children up for adoption? ☐ Yes ☐ No
e. Does Insured contract with a third party to perform genetic testing on children up for adoption? ☐ Yes ☐ No

8.10 Number of foster care placements made by/through Insured: Past Year - Actual:
Next Year - Projected:

8.11	What was the total stipend amount paid to all foster care parents (for placements made by/through Insured) this past year? $	
8.12	What was the number of hours of training received by foster parents, on average, this past year: Prior to placement: After Placement:	
8.13	What is Insured's average number of foster care caseworkers, per manager?	
8.14	What is the turnover rate, annually, of Insured's caseworkers for foster care? %	
8.15	Does Insured 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).	
8.16	On average, how many foster families does Insured use at any given time?	
8.17	What is the maximum number of foster children allowed per foster home by Insured?	
8.18	What is the number of total children (foster, adopted, natural) allowed per foster home?	
8.19	What percentage of children placed by Insured annually are moved at least one time, from one foster home to another? %	
8.20	What is the percentage of children placed by Insured annually, that have physical, developmental or mental disabilities? %	
8.21	What is the percentage of children placed by Insured annually, that are medically fragile? %	
8.22	Does Insured place children with the following disabilities? ☐ Severely Autistic ☐ Profound Mental Retardation ☐ Bedridden Due to Physical Disability	
8.23	How often are foster home inspections performed once a placement is made?	
8.24	Who performs such home inspections?	
8.25	What percentage of all home inspections are: Scheduled: % Unscheduled: %	
8.26	Does each home inspection include a separate consultation alone with the child?	☐ Yes ☐ No
8.27	Which services is the Insured 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 Insured contracts with a third party to provide any of the above services, please indicate which services and provide detail:	
8.28	What steps are taken by Insured in the event of an alleged physical or sexual abuse of a child placed in foster care?	

IX. CLAIMS AND INCIDENTS

Please respond to the following questions to the best of your knowledge and belief, after conducting due diligence and inquiry with <u>any</u> individuals who may have knowledge or information about the matters described below.

9.1	During the past year, has any Insured 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 policy referenced at the top of this application?	☐ Yes ☐ No
9.2	During the past year, has any Insured, or any agent on its behalf, given notice to any 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
9.3	Is any Insured 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 insured, relating to the e policy referenced at the top of this application?	☐ Yes ☐ No
9.4	During the past year, has any insured had a professional license or certification suspended or revoked, or been investigated by any licensing or certification professional organization?	☐ Yes ☐ No

The policy referenced at the top of this application, if renewed, <u>will not insure</u>: 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.

X. 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.

XI. REPRESENTATIONS AND SIGNATURE

By signing this Renewal Application, the undersigned represents and agrees, on behalf of the Named Insured and all 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 his or her knowledge;***
b. ***Those statements and answers furnished to the Company are representations the Named Insured makes on behalf of all insureds;***
c. ***Those representations are a material inducement to the Company to provide a Quotation for a renewal policy;***
d. ***If a renewal policy is issued, the Company will have issued that renewal policy in reliance upon those representations;***
e. ***If there is any material change in the Named Insured's condition, activities or services, or in the statements or answers provided in this Renewal Application, that occurs or is discovered between the date this Renewal Application is signed and the effective date of any renewal policy, if issued, the Named Insured 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.***
g. ***This application is a consideration of coverage and will be physically attached to the policy.***

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

NOTHING IN THIS RENEWAL APPLICATION SHOULD BE INTERPRETED TO MEAN THAT A RENEWAL POLICY WILL BE ISSUED TO THE NAMED INSURED, OR THAT ANY PERSONS, EVENTS OR OTHER SPECIFICS REFERENCED IN QUESTIONS, OR ANSWERS TO QUESTIONS, WILL BE COVERED UNDER ANY RENEWAL POLICY ISSUED TO THE NAMED INSURED.

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

Signature of Authorized Representative of Named Insured	**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**