

Sexual Abuse and Misconduct Liability Supplemental Application

Applicant Information

1. Applicant name:
2. Principal business address (attach separate sheet if more than one location):
 - Street:
 - City:
 - County:
 - State:
 - Zip:
 - Phone:
 - Website:
3. Detailed description of services performed or nature of applicant’s operations

4. Does the applicant maintain any beds for overnight occupancy? Yes No

If Yes, how many?

5. Total number of individual clients served annually:

6. Please breakdown clients served by age group (%):

0-18 % 19-65 % 65+ %

7. Please state sources and amounts of total revenue:

	In last 12 months	For next 12 months
Charitable contributions	\$	\$
Government funding	\$	\$
Fees for service	\$	\$
Other (specify)	\$	\$
Total	\$	\$

Staff Details and Risk Management

8. Current staff breakdown:

Staff Type	Number Employed	Number Contracted	Number Volunteer
Medical professional/licensed			
Non-medical professional/licensed			
Non-professional (describe):			
What percentage of staff (including contractors and volunteers) are:		Female: %	Male: %

9. Please check all methods used to screen new employees or contractors:

Criminal background checks

Verbal reference verification

Written reference verification

Personal interview

Motor vehicles records review

Abuse registry check

Drug Testing

Employment application including question regarding past criminal investigation and sexual/abuse related offenses

10. Are the screening methods checked off in Question 9 above also applied to volunteer staff? Yes No

11. Are you responsible for the oversight of any staff that you do not employ, contract, or have a volunteer agreement with? Yes No

12. If you have any international or foreign staff, please describe background screening methods: None

13. Which of the following abuse risk prevention methods do you use? (mark Y/N)

Written sexual abuse and molestation prevention policy that is read and signed-off on by any new staff?	
Formal, in person training regarding sexual abuse and molestation prevention?	
Zero tolerance policy regarding abuse?	
More than one person responsible for the welfare of any single patient?	
Written policy addressing abuse prevention, including accepted code of conduct?	

14. Are one-on-one encounters permitted with clients? Yes No

If Yes, please provide the percentage of time spent in one-on-one settings: %

15. For any overnight activities with clients, please describe steps taken to prevent contact between clients as well as contact between staff members and clients:

16. How do you handle allegations of sexual abuse or molestation:

Coverage and Claims History

17. a. Does your current insurance program include sexual misconduct coverage? Yes No

b. List prior professional liability insurers for the past three years:

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/aggregate	Deductible	Premium	Coverage type: occurrence or claims-made

c. If the current/expiring policy is on a claims-made form, what is the retroactive date?

(note that we will require proof of current coverage in order to match prior acts coverage).

18. Has any insurer declined, cancelled or non-renewed any professional liability or sexual abuse liability policy for any person(s) or entity(ies) proposed for this insurance? Yes No

If 'Yes,' please provide details in the Additional comments section below.

19. Has (have) any sexual abuse or molestation judgment(s), settlement(s), payment(s), claim(s), suit(s) or demand(s) been made against any person or entity(ies) proposed for this insurance? Yes No

If 'Yes,' please complete a supplemental claim form.

20. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any facts, circumstances or situations which might afford grounds for any sexual abuse or molestation claim? Yes No

If 'Yes,' please provide details in the Additional comments section below.

Additional comments

It is understood and agreed that with respect to questions 18 and 19, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

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 containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of Applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by an electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.