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NIAC #1

General Liability Supplemental Application

(To be submitted with ACORD applications)

Applicant Name: _____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____ ☐ Check here if none available

Email: _____ ☐ Check here if none available Website: _____ ☐ Check here if none available

Confirm Billing Address: _____

Quote Need by Date: _____ Prop. Effective Date: _____

Limits Requested: _____ FEIN #: _____

Please Note: This application is for General Liability only. If additional coverages are desired, please fill out the appropriate application(s) which may be found at https://secure.insurancefornonprofits.org/Brokers-New-Submissions.cfm

GENERAL INFORMATION:

1. Does Applicant currently have any General Liability coverage in force? ☐ Yes ☐ No

   If yes, please submit currently valued loss runs for the past three years and complete the following:

Prior Carrier	Effective Dates	Limit	Premium	Retro Date (if claims made)

2. Is the Applicant a tax-exempt nonprofit organization under the U.S. Internal Revenue Code 501(c)(3), or in the process of obtaining this tax-exempt status? ☐ Yes ☐ No ☐ Pending

   If pending, please attach a copy of their application and check to the IRS confirming they've applied.

   If no, stop. We can only write insurance for tax-exempt 501(c)(3) organizations.

   If name on letter from Dept. of Treasury conferring 501(c)(3) status differs from name of Applicant, please explain:

   _____

3. In what state is the Applicant incorporated? _____

   If Applicant is not incorporated, please explain: _____

   _____

4. What is the Applicant's principal operating state? _____

5. Complete the following:

Annual Budget	Annual Payroll	Annual Sales	Number of Employees	Number of Volunteers

GENERAL INFORMATION: (Cont'd)

6. Specify major sources of funding and indicate approximate proportion of budget from each source (for example: private foundations 20%, city 60%, fee for services 20%):

Source(s) of Funding	% of Total Budget
	%
	%
	%
	%

7. Is Applicant presently in bankruptcy or has Applicant contemplated filing bankruptcy during the past six months? ☐ Yes ☐ No

   If yes, please explain: _____

8. List any licenses or accreditation Applicant is required to maintain: _____

9. In the past five years, has Applicant received any citations, violations, penalties or fines by any administrative or licensing organization? ☐ Yes ☐ No

   If yes, please explain: _____

10. Does Applicant have any subsidiaries or control any other entity or organization for which coverage is desired? ☐ Yes ☐ No

    If yes, please complete the following:

    a. Name of other entity for which coverage is desired: _____

    b. Address (if different from Applicant): _____

    c. What is the relationship between the Applicant and the other organization(s)? _____

11. In the past three years has any insurance carrier declined, canceled or non-renewed any coverage for which Applicant is applying? ☐ Yes ☐ No

    If yes, provide details: _____

General Operations:

12. Please provide a description of Applicant's operations and programs: _____

13. Is the Applicant exclusively an information and referral service (i.e., no direct services)? ☐ Yes ☐ No

14. Approximate number of clients served annually: _____

☐ Children under 10
☐ Youth 10 to 18
☐ Clients over 60 years of age
☐ Developmentally disabled
☐ Low-income/Homeless
☐ Physically disabled
☐ At-Risk/Disadvantaged
☐ Respite/Hospice/Terminally ill
☐ Drug/Alcohol addicted
☐ Dementia/Alzheimer's
☐ Non-ambulatory of any age
☐ Sex offenders
☐ Suicidal
☐ Known violent behavior
☐ Other (describe): _____

15. Does Applicant perform any engineering or restoration work (e.g., waterway or stream restoration)? ☐ Yes ☐ No

16. Is Applicant planning any renovations or new construction during the next two years? ☐ Yes ☐ No

    If yes, please explain: _____

17. Does Applicant accept donations of real property (land or buildings) on a regular basis? ☐ Yes ☐ No

    If yes, describe the type of property accepted including usage (e.g., residential home for rental):

    _____

General Operations: (Cont'd)

18. Does Applicant accept donations of vehicles? ☐ Yes ☐ No

    If yes, explain how Applicant uses these donated vehicles (e.g., used in Applicant's daily operations, sold to a third party; repaired by Applicant and resold, etc.): _____

19. Are any clients held in locked down facilities? ☐ Yes ☐ No

    If yes, please describe: _____

20. Does Applicant provide any Medical Services? ☐ Yes ☐ No

    If yes, please explain: _____

    Is evidence of Medical Malpractice coverage required for all Medical Service Providers employed or contracted by the Applicant? ☐ Yes ☐ No

    If no, please explain: _____

21. Does Applicant employ counselors or other Social Service Professionals (veterinarians, teachers, nurses, etc.)? ☐ Yes ☐ No

    If Social Services Professional Coverage is desired, please complete the "Social Services Professional" Supplemental Application.

Special Events/Fundraisers

Complete the section below to include all of your events and fundraisers.

Note: *We define a "Fundraiser" as any event sponsored or co-sponsored by you with the primary purpose of raising monetary contributions.*

22. Does Applicant hold events/activities outside of Applicant's normal programs and/or operations? ☐ Yes ☐ No

    a. If yes, please complete the table below. If additional space is needed, please attach Special Event form or additional pages.

Event Name & Date	Describe Applicant's Activities Taking Place	# of Expected Attendees	Gross Revenue	Is Applicant a Participant or Host of the Event?	Is Alcohol Served or Sold By Applicant?	Does Applicant Require a Waiver from Participants?
Example: Easter Egg Roll, March 31, 2013	*Egg hunt, picnic lunch, face painting*	*75*	*$0*	*Host*	*n/a*	*n/a*
			$			
			$			
			$			

    b. If yes, are vendors/exhibitors required to provide proof of General Liability insurance naming the Applicant as an Additional Insured? ☐ Yes ☐ No

    c. Which events listed in 22.a. above have bounce houses, inflatables and/or climbing structures?

Name of Event: _____ # of Structures: _____

Name of Event: _____ # of Structures: _____

Name of Event: _____ # of Structures: _____

    d. Describe the security and safety procedures in place for the events listed in 22.a. above:

Name of Event: _____ Procedures: _____

Name of Event: _____ Procedures: _____

Name of Event: _____ Procedures: _____

Athletics/Sports

23. Does Applicant offer athletics/sports programs? ☐ Yes ☐ No

If yes, please answer the following:

a. Describe all athletic activities provided: _____

_____

b. Number of annual participants: _____

e. Indicate type of sports offered (e.g., basketball, flag football, boxing, soccer, cheerleading): _____

_____

_____

f. Does your organization sponsor competitions or teams that participate in competitions? ☐ Yes ☐ No

If yes, is Applicant responsible for insuring these competitions or teams? ☐ Yes ☐ No

g. Are waiver/release/hold harmless agreements obtained for all participants? ☐ Yes ☐ No

Foster Homes

24. Does Applicant certify Foster Homes? ☐ Yes ☐ No

If yes, please answer the following:

a. Does Applicant purchase Foster Parent Liability (FPL) insurance for foster parents? ☐ Yes ☐ No

If no, please note that we usually require this be purchased concurrent with our liability coverage.

If yes, please provide a copy of Applicant's current FPL declaration page.

b. Number of homes that Applicant certifies: _____

Number of homes that Applicant has decertified over the past five years: _____

c. Number of children placed in homes by Applicant annually: _____

d. Number of years experience of Applicant's executive director in this field: _____

e. Are Applicant's foster care procedures/practices subject to state regulation? ☐ Yes ☐ No

f. Total number of training hours for each family prior to placement of each child: _____

g. Does Applicant provide follow-up visits to homes after children are placed? ☐ Yes ☐ No

If yes, how frequently? _____ Are the visits unannounced? ☐ Yes ☐ No

Do home visits include a private consultation with the foster children? ☐ Yes ☐ No

When do these visits stop? _____

h. Does Applicant conduct checks of criminal records of foster parents and other residents prior to approval of home? ☐ Yes ☐ No

Are foster parents or other residents in the home who have criminal records, or any history of physical or sexual abuse immediately disapproved or decertified? ☐ Yes ☐ No

If no, please explain: _____

_____

i. Does Applicant have written procedures for responding to reports of abuse? ☐ Yes ☐ No

j. What is the average case load per employee/social worker? _____

Adoptions

25. Does Applicant provide adoption services? ☐ Yes ☐ No

If yes, please answer the following:

a. Are any adoptions "closed?" ☐ Yes ☐ No

If yes, please explain: _____

b. Number of adoptions performed annually: _____

c. Number of adoptions that are international: _____

d. Are you a member of the Joint Council on International Adoption or another similar organization? ☐ Yes ☐ No ☐ Other

If other, please specify: _____

Premises

26. Does Applicant provide lodging or operate residential facilities? ☐ Yes ☐ No

If yes, please answer the following:

a. Number of beds for which Applicant is licensed, and square footage of each facility: _____

_____

b. Number of stories in each building: _____

c. If two stories or more, number of means of egress: _____

d. Average length of stay per resident: _____

e. Age range of residents: ☐ 0-10 ☐ 11-18 ☐ 19-65 ☐ over 65

f. Percentage of non-ambulatory residents: _____%

g. Is there a 24-hour resident manager? ☐ Yes ☐ No

h. Is staff trained in a formal procedure for medical emergencies? ☐ Yes ☐ No

i. Is skilled nursing or medical care provided? ☐ Yes ☐ No

27. Does Applicant have a fire alarm system? ☐ Yes ☐ No

28. Does Applicant have smoke detectors on premises? ☐ Yes ☐ No

29. Is smoking allowed inside any premises? ☐ Yes ☐ No

30. Does Applicant have a swimming pool? ☐ Yes ☐ No

If yes, please answer the following:

a. Is pool fenced with a self-closing gate? ☐ Yes ☐ No

b. Is there a diving board? ☐ Yes ☐ No

c. Is there life-saving equipment accessible? ☐ Yes ☐ No

31. Does Applicant own, lease or rent any vacant buildings? ☐ Yes ☐ No

If yes, please explain reason for vacancy, plans and time frame for occupancy: _____

_____

32. Does Applicant offer your premises to others, either for rent or for free? ☐ Yes ☐ No

If yes, please answer the following:

a. Please explain general use and frequency: _____

b. Does Applicant obtain certificates of insurance showing proof of liability insurance from all who use the facility? ☐ Yes ☐ No

Animals

33. Does Applicant have any exposures involving animals? ☐ Yes ☐ No

34. Does Applicant have any saddle animal operations? ☐ Yes ☐ No

If yes, please answer the following:

a. Are animals used solely for therapeutic purposes? ☐ Yes ☐ No

If no, explain other usage: _____

b. Are safety helmets required? ☐ Yes ☐ No

c. Are animals: ☐ Owned by Applicant ☐ Furnished to Applicant by third party

d. Number of animals owned by or used by Applicant: _____

35. Does Applicant provide animal shelter/rescue services? ☐ Yes ☐ No

If yes, please indicate the number of:

a. Spaces, cages or kennels on Applicant's premises available to animals: _____

b. Animals placed in foster care annually: _____

c. # dog foster homes # cat foster homes # other foster homes

d. Offsite adoptions held annually: _____

e. Are all animals vaccinated and held for observation prior to being placed in any homes (adoptive or foster)? ☐ Yes ☐ No

f. Is a health assessment of the animal conducted by a professional qualified to assess communicable disease? ☐ Yes ☐ No

g. Are behavioral evaluations performed by a qualified professional of all animals prior to placement (foster or adoption)? ☐ Yes ☐ No

h. Does Applicant place animals with known (current or historical) biting issues into homes (foster or adoption)? ☐ Yes ☐ No

i. Are waivers for volunteers of adoptive/foster homes maintained and do they include hold harmless language that specifically discloses that the animal may cause bodily injury to the volunteer, and that the volunteer will not hold the nonprofit responsible for any injury to themselves or family members that arise from the foster/adoptive relationship? ☐ Yes ☐ No

j. Does Applicant have accident coverage in place? ☐ Yes ☐ No

k. How long has Applicant been in business? _____

l. How many years experience does the Applicant's leadership have in this field? _____

36. Does Applicant employ animal control officers? ☐ Yes ☐ No

If yes, please answer the following:

a. How many? _____

b. Do they carry firearms? ☐ Yes ☐ No

c. Do these officers carry separate professional liability insurance? ☐ Yes ☐ No

37. Does Applicant operate any of the following? ☐ Yes ☐ No

If yes, provide annual sales for each:

Type	Annual Sales
☐ Pet Training	$
☐ Pet Grooming	$

Performing and Fine Arts

38. Does Applicant offer Performing or Fine Arts? ☐ Yes ☐ No

If yes, please answer the following:

a. Description of performances (e.g., dance, musical, plays): _____

b. Annual number of performances: _____

c. Average attendance at each performance: _____

d. Are performances held at premises owned or leased by Applicant? ☐ Yes ☐ No

e. Are any performances held away from premises owned or leased by Applicant? ☐ Yes ☐ No

f. Does Applicant provide concessions? ☐ Yes ☐ No

If yes, please provide annual receipts: $ _____

g. Does Applicant provide classes to the public? ☐ Yes ☐ No

Camping/Campgrounds

39. Does Applicant own or operate a campground? ☐ Yes ☐ No

If yes, please answer the following:

a. Is a caretaker present during off-season(s) (i.e., when camp sessions are not in session)? ☐ Yes ☐ No

b. Is camp located in a wilderness area? ☐ Yes ☐ No

c. Is camp located in an area at risk of wildfires? ☐ Yes ☐ No

40. Does Applicant provide camping experiences for clients? ☐ Yes ☐ No

If yes, please answer the following:

a. Describe any special focus and/or activities offered (river rafting, ropes courses, climbing walls, etc.):

_____

b. Annual number of campers per day: _____

c. Number of days camp has campers on location each year: _____

d. Is there overnight exposure? ☐ Yes ☐ No

Mentoring programs (e.g. Big Brothers Big Sisters)

41. Does Applicant have any mentoring programs that match youth with mentors? ☐ Yes ☐ No

If yes, please answer the following:

a. How many matches are made annually? _____

b. Is there a formal training and screening program in place? ☐ Yes ☐ No

c. Are any matches made of opposite genders? ☐ Yes ☐ No

If yes, explain: _____

d. Are permission slips obtained for all mentors/mentees under 18? ☐ Yes ☐ No

e. Are mentors allowed to take mentees to their private residence? ☐ Yes ☐ No

Food or Merchandise Distribution (e.g. Food Banks, Thrift Stores, Meal Delivery, etc.)

42. Does Applicant distribute or sell any food or merchandise? ☐ Yes ☐ No

Type	Gross Sales or Value of Goods Distributed
☐ Food	$
☐ Used Merchandise	$
☐ Other (describe):	$

Other Exposures

43. Does Applicant have any premises, operations or exposures that are not stated in this application? ☐ Yes ☐ No

If yes, describe and state whether they are insured elsewhere: _____

_____

_____

_____

_____

_____

_____

SIGNATURES

Notice: This risk pooling contract is issued by a pooling arrangement authorized by California Corporations Code Section 5005.1. The pooling arrangement is not subject to all of the insurance laws of the State of California and is not subject to regulation by the Insurance Commissioner. Insurance guaranty funds are not available to pay claims in the event the risk pool becomes insolvent.

Applicant's Signature	Date	Producer's Signature	Date
Print or type applicant's name		Applicant's Title	

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NIAC #3

Social Service Professional Liability Supplemental Application

Applicant Name: _____

Quote Need by Date: _____ Prop. Effective Date: _____

Limits Requested: _____

Please Note: This application is for Social Service Professional Liability coverage, and can only be bound in conjunction with a General Liability policy. For complete instructions on our submission requirements, please visit https://secure.insurancefornonprofits.org/Brokers-New-Submissions.cfm

SOCIAL SERVICE PROFESSIONAL LIABILITY (SSP)

1. Indicate the number of professionals that currently work as Employees, Volunteers, and Independent Contractors in the following professional capacities: If none, please check here: ☐ None

Provider	Employees		Volunteers		Independent Contractors	
	FT	PT	FT	PT	FT	PT
Acupuncturist						
Adoption Service Employee						
Aide						
Assisted Living Provider						
Certified Enrollment Counselor						
Childcare Worker						
Chiropractor						
CNA/LPN/Nurse Assistant						
Coach/Assistant Coach						
Companion Care/Home Aide						
Daycare Provider						
Dental Hygienist/Assistant						
Educator/Instructor/Teacher						
Group Home/Supported Living Provider						
Home Health Aide (greater skill than Companion)						
Intake Coordinator/Specialist						
Mentor/Tutor						
Nutritionist/Dietician						
Optician						
Personal Care Attendant						
Phlebotomist						
Psychologist/Psychotherapist						
Recreational Instructor						
RN						
Social Worker/Case Worker						
Therapist/Counselor (All)						
Veterinarian						
Other Professionals (describe):						

2. Indicate number of Annual Medical Professional Staffing – Employees, Volunteers and Independent Contractors working for Applicant in the following medical professional capacities:

If none, please check here: ☐ None

Medical Services Provider	Employees		Volunteers		Independent Contractors	
	FT	PT	FT	PT	FT	PT
Dentist						
Nurse Anesthetist, Midwife and/or Nurse Practitioner						
Optometrist						
Paramedic/EMT						
Pharmacist						
Physician Assistant						
Physician/Surgeon/Psychiatrist						

Note: Our policy may extend vicarious professional coverage to the nonprofit entity as respects professional services rendered on the insured's behalf only if the above employed or volunteer professionals carry their own medical malpractice insurance with a minimum limit of liability of $1,000,000.

3. Does Applicant use any independent contractors? ☐ Yes ☐ No

If yes:

a. Does Applicant require them to sign a hold harmless or indemnification agreement? ☐ Yes ☐ No

b. Does Applicant require and maintain on file certificates of insurance for each independent contractor reflecting minimum limits of liability of $1,000,000? ☐ Yes ☐ No

c. Does Applicant require that all independent contractors name your organization as an Additional Insured on their insurance policy? ☐ Yes ☐ No

Note: Typically, independent contractors/1099 workers are expected to procure their own insurance. Independent contractors/1099 workers are not covered under the policy for which Applicant is applying unless a special endorsement is added to the policy. If you would like us to consider adding this special endorsement to cover independent contractors/1099 workers providing services on your behalf, please indicate here ☐ and attach a list including the first and last name and a description of services provided by each independent contractor/1099 worker.

4. Does Applicant provide services to bi-polar, severely autistic, schizophrenic, paranoid, psychotic, severely mentally ill clients or to adjudicated sex offenders? ☐ Yes ☐ No

If yes, please provide details: _____

5. What security is provided for protection and/or monitoring of Applicant's clients/residents?

☐ None ☐ Guards ☐ Video Cameras ☐ Other (describe): _____

6. What method does Applicant use for de-escalation with agitated clients? _____

7. Does Applicant diagnose clients/residents? ☐ Yes ☐ No

8. Does Applicant prescribe or provide medication to clients/residents? ☐ Yes ☐ No

If yes, please provide details: _____

_____

9. Does Applicant verify licenses and other credentials of staff before hiring? ☐ Yes ☐ No

a. If no, please explain: _____

b. If yes, are procedures in place to verify current licenses are maintained and in good standing? ☐ Yes ☐ No

10. Does Applicant have a formal incident procedure in place that requires staff to report to an administrator all incidents that may result in a claim? ☐ Yes ☐ No

If yes, is a written record kept and reviewed regularly? ☐ Yes ☐ No

11. Has Applicant or Applicant's staff ever:

a. Been reprimanded, refused admission or suspended by any association or administrative agency? ☐ Yes ☐ No

b. Had their license been under investigation, suspended, revoked, voluntarily surrendered or placed under conditional status? ☐ Yes ☐ No

If yes to either 11.a. or 11.b. above, please provide details: _____

12. Does Applicant provide home health services? ☐ Yes ☐ No

If yes, does Applicant:

a. Require written plan by attending physician of clients prior to being accepted for home health services? ☐ Yes ☐ No

If no, please explain: _____

b. Require all clients receiving any level of skilled care to have a current and regularly updated physician treatment plan on file? ☐ Yes ☐ No

c. Are written, enforced and monitored policies and procedures in place regarding the following?

1) Medical record documentation? ☐ Yes ☐ No
2) Incident reporting? ☐ Yes ☐ No
3) Employee training? ☐ Yes ☐ No
4) Handling of complaints? ☐ Yes ☐ No
5) When providers should contact a physician? ☐ Yes ☐ No
6) Client care home visits documentation? ☐ Yes ☐ No
7) Clients no longer meet the criteria for home care? ☐ Yes ☐ No
8) Clients should be transferred to a hospital? ☐ Yes ☐ No

If no to any of 12.c., please explain: _____

_____

Claims and Insurance Information

13. Has Applicant had any claims and/or incidents in the past three (3) years? ☐ Yes ☐ No

We require currently valued loss runs for the past three (3) years as well as a completed ANI Claims Supplemental Application for each claim that has been reported under any Professional Liability policy. If no coverage was in force, but a claim was made or an incident did occur, complete the Claims Supplemental Application to describe each incident.

14. Does Applicant have knowledge or information of any incident which might give rise to a claim? ☐ Yes ☐ No

If yes, please explain: _____

15. Has any insurance carrier declined to issue a Professional Liability policy to Applicant? ☐ Yes ☐ No

If yes, please explain: _____

16. Has any insurance carrier canceled or non-renewed any of Applicant's Professional Liability coverage? ☐ Yes ☐ No

If yes, please explain: _____

17. Does Applicant currently have any Professional Liability coverage in force? ☐ Yes ☐ No

a. If yes, please complete the following:

Company	Effective Dates	Limits of Liability	Deductible	Annual Premium

b. If yes, is current Professional Liability coverage written on a claims-made basis? ☐ Yes ☐ No

c. If yes to 17.b. above, indicate current Retroactive Date: _____

Signatures

The undersigned is an authorized representative of the Applicant and certifies that reasonable inquiry has been made to obtain the answers to questions on this application. He/she certifies that the answers are true, correct and complete to the best of his/her knowledge.

Applicant's Signature	Date	Producer's Signature	Date
Print or type Applicant's name		Applicant's Title	

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NIAC #4

Improper Sexual Conduct Liability Supplemental Application

Applicant Name: _____

Quote Need by Date: _____ Prop. Effective Date: _____

Limits Requested: _____

Please Note: This application is for Improper Sexual Conduct Liability (ISC) coverage, and can only be bound in conjunction with a General Liability policy. For complete instructions on our submission requirements, please visit https://secure.insurancefornonprofits.org/Brokers-New-Submissions.cfm

IMPROPER SEXUAL CONDUCT LIABILITY (ISC)

1. a. In the past three (3) years, has any insurance carrier declined, canceled or non-renewed any Improper Sexual Conduct Liability coverage for which Applicant has applied? ☐ Yes ☐ No

   If yes, please explain: _____

   b. Does Applicant have knowledge or information of any incidents which might reasonably be expected to give rise to a claim? ☐ Yes ☐ No

   c. Attach currently valued loss runs for the past three (3) years as well as a completed NIAC/ANI #11 Claims Supplemental Application for each claim that has been reported under any Improper Sexual Conduct Liability policy in the last three (3) years. If no coverage was in force, but an incident did occur, please complete the #11 Claims Supplemental Application to describe each incident. If none, please check here: ☐ None

2. Does Applicant currently have any Improper Sexual Conduct coverage in force? ☐ Yes ☐ No

   If yes, please complete the following:

Prior Carrier	Effective Dates	Limit	Retro Date (if claims made)	Premium

We require background checks only for those employees or volunteers of Applicant who have supervisory or disciplinary powers over minors, or provide care for the elderly, the handicapped or mentally impaired. The following questions apply to those individuals. A discounted background check service is available to our insured members.

3. Does Applicant obtain background checks for employees? ☐ Yes ☐ No
4. Does Applicant obtain background checks for volunteers? ☐ Yes ☐ No
5. Does Applicant require evidence that background checks are performed on Independent Contractors? ☐ Yes ☐ No

   If no, please explain: _____

6. Do any employees or volunteers have unsupervised contact with clients? ("Unsupervised" means in the presence of one client without direct oversight by at least one other employee or volunteer.) ☐ Yes ☐ No

   If yes, please explain: _____

7.	Is there written protocol surrounding the handling of allegations of sexual abuse?	☐ Yes ☐ No
8.	Are employees/volunteers trained in this protocol?	☐ Yes ☐ No

SIGNATURES

Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and (NY: substantial) civil penalties. (Not applicable in CO, HI, NE, OH, OK, OR, OR VT. In DC, LA, ME, TN and VA, insurance benefits may also be denied). The undersigned is an authorized representative of the Applicant and certifies that reasonable inquiry has been made to obtain the answers to questions on this application. He/she certifies that the answers are true, correct and complete to the best of his/her knowledge.

Applicant's Signature	Date	Producer's Signature	Date
Print or type Applicant's name		Applicant's Title	

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NIAC #5

Directors and Officers Liability and Employment Practices Liability Supplemental Application

Applicant Name: _____

Quote Need by Date: _____ Prop. Effective Date: _____

Limits Requested: _____

Please Note: This application is for Directors and Officers Liability coverage, and can only be bound in conjunction with a General Liability policy. For complete instructions on our submission requirements, please visit https://secure.insurancefornonprofits.org/Brokers-New-Submissions.cfm

DIRECTORS AND OFFICERS LIABILITY AND EMPLOYMENT PRACTICES LIABILITY (D&O and EPLI)

Board Management

1. Indicate total number of board members: _____

   If fewer than three (3), please contact your underwriter to discuss an exception to this requirement.

2. Is the number of board members currently serving on Applicant's board of directors in compliance with the number required by the Bylaws or Articles of Incorporation of the organization? ☐ Yes ☐ No

   If no, please explain: _____

3. Have more than forty-nine percent (49%) of the members of Applicant's board of directors received compensation within the previous twelve (12) months for their services to the nonprofit, either as an employee or independent contractor? ☐ Yes ☐ No

   If yes, please explain: _____

4. Are more than forty-nine percent (49%) of the members of Applicant's board of directors related (sibling, spouse, in-law, or descendent) to a person currently being compensated as described in 3. above? ☐ Yes ☐ No

   If yes, please explain: _____

5. a. Are board meetings held at least two (2) times per calendar year? ☐ Yes ☐ No

   b. Are written minutes of board and committee meetings kept? ☐ Yes ☐ No

   c. Is attendance kept for every board meeting? ☐ Yes ☐ No

6. Does the board approve compensation of the following:

   a. Executive Director or CEO: ☐ Not applicable ☐ Yes ☐ No

   b. CFO, Treasurer or Financial Manager: ☐ Not applicable ☐ Yes ☐ No

   c. Is compensation of the positions listed above comparable to salaries in the marketplace? ☐ Yes ☐ No

7. Has the board of directors of Applicant discussed the unsatisfactory performance of the Executive Director or other key management personnel during the past twelve (12) months? ☐ Yes ☐ No

   If yes, please explain: _____

Financial Information

8. a. Please provide the following financial information for the Applicant. Check here if new organization and provide estimates below: ☐

990 LINE ITEM	FINANCIAL INFORMATION	MOST CURRENT FISCAL YEAR YE	PREVIOUS FISCAL YEAR YE
Line 12	Annual Revenue	$	$
Line 18	Annual Expenses	$	$
Line 19	Net Revenue	$	$
Line 20	Total Assets	$	$
Line 21	Total Liabilities	$	$
Line 22	Fund Balance*	$	$

*(Fund Balance = Total Assets – Total Liabilities)

b. If current year reported above indicates a negative fund balance, please provide an explanation that includes steps Applicant is taking to avoid in the future and submit the most recent 990 Tax Form or Audited Financials including notes.

_____

9. a. Has Applicant made any loans to, or received loans from, key employees or board members? ☐ Yes ☐ No

b. If yes, please provide loan details:

From: _____ To: _____

Reason: _____

Amount: _____ Interest: _____

Terms: _____

10. For the most recent fiscal year, has Applicant reported any Related Party Transactions in their financial statement? ☐ Yes ☐ No

If yes, Applicant will be prompted to attach audited financials including notes before submitting app.

Employment Practices

11. a. Does Applicant have employees? ☐ Yes ☐ No

b. If no: An Applicant that has no employees is eligible for our Flat-Fee D&O policy which excludes Employment Practices Liability coverage. If Applicant is interested in our Flat-Fee policy, check here: ☐

c. If yes, please indicate number of current employees:

Full Time	Part Time	Temporary/Seasonal

12. a. How many employees have left the organization in the past twelve (12) months? If none, check here: ☐

Voluntary	Involuntary	Laid Off	Demoted

b. If Applicant's most <u>recent</u> annual turnover rate is greater than thirty percent (30%), please explain:

_____

13. Is any significant reduction of employees or change of employee status anticipated in the next twelve (12) months? ☐ Yes ☐ No

If yes, please explain: _____

14. Indicate date Personnel Handbook was last updated by a Labor Law Professional: _____

If Applicant does not have a Personnel Handbook in place, check here: ☐

Employment Practices (continued)

15. Please indicate whether Applicant has the following written policies or procedures in place:
    a. Employment At-Will: ☐ Yes ☐ No
    b. Sexual Harassment Complaint Procedure: ☐ Yes ☐ No
    c. Anti-Retaliation (including employee whistleblower protection): ☐ Yes ☐ No
    d. Accommodation of Disabled Employees: ☐ Yes ☐ No

Claims and Insurance Information

Important Notice: All known claims and/or incidents that could reasonably result in a claim are specifically excluded from coverage. Report all such claims to your current insurer.

16. Has Applicant been involved in any grievance or other administrative proceeding before any agencies in the last five (5) years? ☐ Yes ☐ No

    If yes, please explain: _____

17. Does Applicant have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim, including any employment-related actions, claims or suits? ☐ Yes ☐ No

    If yes, please complete a Supplemental Claims Application #11 for each incident.

18. Attach currently valued loss runs for the past five (5) years as well as a completed supplement for each claim that has been reported under any Directors and Officers, Fiduciary Liability, and/or Employment Practices Liability policy in the last five (5) years. If no coverage was in force, but an incident did occur, please complete the Supplemental Claims Application #11 to describe each incident.

    If none, check here: ☐

19. In the past five (5) years, has any insurance carrier declined, canceled or non-renewed any D&O coverage? ☐ Yes ☐ No

    If yes, please explain: _____

20. Provide the following information regarding Applicant's current insurance policies. If none, so indicate.

Type of Policy:	Insurance Carrier	Expiration Date	Limit	Deductible	Premium
Directors & Officers: If none, check here: ☐					
Employment Practices Liability: If none, check here: ☐					
Fiduciary Liability (other than ERISA): If none, check here: ☐					

Optional Questions - Board Governance

21. Is a procedure in place for replacing board members who do not attend board meetings regularly? ☐ Yes ☐ No
22. Is an orientation provided for new board members? ☐ Yes ☐ No
23. Does the board have an Audit Committee that is independent of management (i.e., paid managers do not serve on this committee)? ☐ Yes ☐ No
24. Has the board adopted a Conflict of Interest policy? ☐ Yes ☐ No
25. How many years has the current Executive Director been employed in this position? _____
26. Does the Board of Directors conduct an annual written review of the performance of the Executive Director/CEO? ☐ Yes ☐ No

SIGNATURES

The undersigned authorized officer of the Applicant declares that the statements set forth herein are true. The undersigned authorized officer agrees that if the information supplied on this application changes between the date of this application and the effective date of the coverage, he/she (undersigned) will immediately notify Nonprofits' Insurance Alliance of California (NIAC) of such changes, and NIAC may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the coverage.

Signing of this application does not bind NIAC to issue nor the Applicant to buy the coverage, but it is agreed that this form shall be the basis of the contract should a policy be issued and it will be attached to and be made a part of the policy.

All written statements and materials furnished to NIAC in conjunction with this application are hereby incorporated by reference into this application and made a part hereof.

Applicant's Signature	Date	Producer's Signature	Date
Print or type applicant's name		Applicant's Title	

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NIAC #7

Accident Coverage Supplemental Application

Applicant Name: _____

1. How many months per year is Applicant in operation? _____
2. If Applicant has purchased Accident coverage before, please submit currently valued loss runs for the past three (3) years.

Please Note: This application is for Accident Coverage, and can only be bound in conjunction with a General Liability policy. For complete instructions on our submission requirements, please visit https://secure.insurancefornonprofits.org/Brokers-New-Submissions.cfm

ACCIDENT COVERAGE - ***A program of QBE Insurance Corporation***

PLEASE NOTE:

- ***Does Applicant operate an agency with a continuous 24 hour exposure? Examples include a residential group home or volunteers providing foster care services for animals. If yes, please stop – a 24 hour exposure is not eligible for coverage under this Accident program.***
- ***Accident coverage is available for volunteers and/or participants. Please indicate below which type is to be included under the accident coverage.***

Please Answer <u>All</u> of the Following Questions:

Group Type

3. Check off the group type which matches Applicant's own. If Applicant's group is a mix, insert percentages, making sure the total adds up to 100%. If Applicant's group is not listed, describe Applicant's operation in the space provided below:

☐	_____%	Child Day Care	☐	_____%	Business	☐	_____%	Vocational Training
☐	_____%	Theater	☐	_____%	Fund Raising	☐	_____%	Community/Housing
☐	_____%	Music/Choral	☐	_____%	Environmental	☐	_____%	Senior Citizen Center
☐	_____%	Youth	☐	_____%	Cultural/Social	☐	_____%	Elderly/Infirm Care
☐	_____%	Schools	☐	_____%	Construction	☐	_____%	Other (describe): _____

Volunteers ***(One who enters into or offers himself for a service of his own free will, and who the nonprofit organization would consider a volunteer)***

Please complete this section if coverage for volunteers is desired.

4. a. Indicate the number of volunteers who give their time to Applicant's organization:

One Day Per Year	Regular Volunteer

b. If Applicant's organization has regular volunteers, indicate the average number of days per year volunteers give their time: _____

Participants ***(A registered person participating in supervised and sponsored activities that the nonprofit organization is making available or is responsible for)***

Please complete this section if coverage for participants is desired.

5. a. Indicate the number of participants who attend activities with Applicant's organization:

One Day Per Year	Regular Participation

b. If participants regularly participate in activities of the Applicant's organization, please indicate the average number of days per year they participate: _____

Other Exposure

6. If any participant/volunteer participates in any of the activities listed below, please complete the chart. If none of these activities apply, indicate by checking this box: ☐ None apply

Activity	Number of Participants	Number of Volunteers	Approximate Number of Days Per Year
Non-Contact Sports			
Contact Sports			
Bus/Van Trips over 200 miles			
Trips by Air			
Foreign Trips *			
Heavy Manual Labor			
24-Hour Activity			
Trips/Outings over 2 days long			

* Please indicate the duration and destination of the foreign trip(s): _____

_____

Definitions:

Non-Contact Sports - Sports or athletic activities (excluding contact sports) with a schedule and registered regular participants or team roster.

Contact Sports - Football, hockey, lacrosse, soccer, rugby and boxing.

Heavy Manual Labor - Construction work, regular work with power tools, industrial manufacturing, or commercial agriculture.

24-Hour Activity - Any activity lasting continuously for 24 hours or more.

BENEFIT PLAN DESIRED

Place "X" in box below indicating plan preferred.

"X"	Plan	Accident/Aggregate	Deductible Requested	Accidental Death & Dismemberment
☐	A	$10,000	☐ $0 ☐ $50 ☐ $100 ☐ $250	$50,000
☐	B	$25,000	☐ $0 ☐ $50 ☐ $100 ☐ $250	$50,000
☐	C	$50,000	☐ $50 ☐ $100 ☐ $250	$50,000
☐	D	$75,000	☐ $50 ☐ $100 ☐ $250	$50,000
☐	E	$100,000	☐ $50 ☐ $100 ☐ $250	$50,000
☐	F	$250,000	☐ $50 ☐ $100 ☐ $250	$50,000

AD&D Aggregate Limit of Liability: $750,000.

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NIAC #8

Employee Benefits Liability Supplemental Application

Applicant Name: _____

Please Note: This application is for Employee Benefits Liability coverage, and can only be bound in conjunction with a General Liability policy. For complete instructions on our submission requirements, please visit https://secure.insurancefornonprofits.org/Brokers-New-Submissions.cfm

EMPLOYEE BENEFITS LIABILITY (EBL)

1. a. In the past three (3) years, has any insurance carrier declined, canceled or non-renewed any Employee Benefits Liability coverage for which Applicant has applied? ☐ Yes ☐ No

   If yes, please explain: _____

   b. Does Applicant have knowledge or information of any incidents which might reasonably be expected to give rise to a claim? ☐ Yes ☐ No

   c. Attach currently valued loss runs for the past three (3) years as well as a completed NIAC/ANI #11 Claims Supplemental Application for each claim that has been reported under any Employee Benefits Liability policy in the last three (3) years. If no coverage was in force, but an incident did occur, please complete the #11 Claims Supplemental Application to describe each incident. If none, please check here: ☐ None

2. Does Applicant currently have any Employee Benefits Liability coverage in force? ☐ Yes ☐ No

   If yes, please complete the following:

Prior Carrier	Effective Dates	Limit	Retro Date (if claims made)	Premium

3. Are benefits offered to all regular, full-time employees? ☐ Yes ☐ No
4. Are any benefits offered to part-time employees? ☐ Yes ☐ No
5. Is a signed acceptance/rejection form kept in all employees' personnel files? ☐ Yes ☐ No
6. Has there ever been a dispute or threatened dispute over benefits? ☐ Yes ☐ No
7. Does Applicant have a pension/retirement plan available to your employees? ☐ Yes ☐ No

   If yes, please complete the following:

   a. Plan is managed by: ☐ Applicant ☐ Third Party Administrator - Name: _____

   b. Is the administrator of the plan also an investment advisor registered with the Securities and Exchange Commission? ☐ Yes ☐ No

   c. Investment decisions are made by: ☐ Applicant ☐ Employees

   d. Does Applicant provide investment advice to employees? ☐ Yes ☐ No

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NIAC #10

Non-Owned & Hired / Commercial Auto Coverage Supplemental Application

(To be submitted with ACORD applications)

Applicant Name: _____

Please Note: This application is for Non-Owned & Hired/Commercial Auto coverage, and can only be bound in conjunction with a General Liability policy. For complete instructions on our submission requirements, please visit https://secure.insurancefornonprofits.org/Brokers-New-Submissions.cfm

Note: All owned or leased vehicles must be registered to the Applicant.

NON-OWNED & HIRED / COMMERCIAL AUTO COVERAGE

1. Does Applicant currently have any Non-Owned & Hired/Commercial Auto coverage in force? ☐ Yes ☐ No

   If yes, please submit currently valued loss runs for the past three years and complete the following:

Prior Carrier	Effective Dates	Premium

2. Does Applicant have a procedure in place to verify personal auto insurance for all employees and volunteers who may use their autos for company business? ☐ Yes ☐ No

   If no, Applicant will be required to put in process such a procedure to qualify for Non-Owned Auto coverage.

3. How many employees/volunteers drive their personal vehicles regularly on behalf of Applicant? _____

   a. About how often does a typical volunteer or employee of Applicant drive his or her vehicle on behalf of Applicant?

      ☐ Daily ☐ 1-3 times per week ☐ Less than once per week ☐ Few times a year

   b. Vehicle Usage (check all that apply): ☐ Meal Delivery ☐ Errands/Business Travel

      ☐ Other - Describe: _____ ☐ Transport Clients/Residents – Frequency: _____

4. Does Applicant's organization rent/hire vehicles? ☐ Yes ☐ No

   If yes, indicate annual estimated cost of hire or rental: _____

5. Does Applicant own or lease any vehicles or mobile equipment (do not include short-term rentals)? ☐ Yes ☐ No

   If yes, please answer the following:

   a. How many vehicles? _____

   b. Are any of Applicant's vehicles equipped with a wheelchair lift? ☐ Yes ☐ No

      If yes, please describe the training provided to drivers: _____

      _____

Please Note: We no longer order, request, add, delete, maintain or evaluate MVRs and driver records for the policies. We ask that the nonprofit follow our guidelines when deciding whether to allow someone to drive. Our underwriting criteria for drivers of agency owned vehicles can be found at: http://www.niac.org/Business-Auto-Guidelines-Drivers-Agency-Vehicles.cfm

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NIAC #11

CLAIMS SUPPLEMENTAL APPLICATION

This form is to be completed if the Applicant or Insured has been involved in any Claim, Suit or Disciplinary Proceeding or is aware of such an Incident which may give rise to a claim in the past five (5) years.

One supplemental claims application should be completed for **each Claim/Incident.**

Claim Details

1. Applicant Name: _____
2. Full names of individual(s) involved in Claim/Incident: _____
3. Full name of Claimant: _____
4. Date Claim/Incident occurred: _____
5. Narrative and background on Claim/Incident: _____

   _____

   _____
6. What measures have been taken to prevent a recurrence of a similar Claim/Incident? _____

   _____
7. Please indicate status: ☐ In Suit ☐ Open Incident/Potential Claim ☐ Formal Open Claim ☐ Closed Claim
8. If Claim/Incident is closed, please indicate the following: ☐ Court Judgment ☐ Out of Court Settlement

   Total loss paid including deductible(s): $ _____

Signatures

The information on this supplemental Application is material to NIAC underwriting this risk and shall be deemed attached a part of this Policy as if physically attached hereto.

_____ _____

Name *(Please Print)* | Title *(Must be a President, CEO, ED, Chairperson, CFO or Treasurer)*

_____ _____

Applicant's Signature *(Must be signed by a President, CEO, ED, Chairperson, CFO or Treasurer)* | Date

The above signed warrants that he/she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the Applicant and their respective Directors, Officers or other insured persons.

_____

Insurance Broker/Producer