Pennock Insurance, Inc.
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Chadds Ford, PA 19317
1.800.662.5182 Call
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Social Service Agencies

Program Application and Coverage Summary

COVERAGES

PROFESSIONAL LIABILITY: Coverage can be provided on both an occurrence and claims made basis. The policy covers the legal liability of the insured for injury arising out of professional services provided. The protection also applies to officers, board members, volunteer workers and employees including physicians while acting on behalf of the named insured.

COMMERCIAL GENERAL LIABILITY: The form covers legal liability for bodily injury, property damage, advertising and personal injury arising out of operations of the insured. Stop Gap is available where appropriate. GL coverage is not available on a stand-alone basis, but must be written in conjunction with Professional Liability.

EMPLOYEE BENEFITS LIABILITY: Errors and Omissions coverage in the administration of employee benefit plans (other than pension plans subject to ERISA).

OPTIONS AVAILABLE:

- Separate Limits of Insurance for Professional and General Liability
- Limits available up to $3,000,000 occurrence/$5,000,000 aggregate
- Employer's Non-owned Automobile Liability
- Volunteer and Non-residential Client Accident Coverage
- Physical and Sexual Abuse Coverage

SUPPORTING PROGRAMS FOR SOCIAL SERVICE AGENCIES

EXCESS LIABILITY/UMBRELLA: Coverage is available with limits up to $10,000,000.

DIRECTORS AND OFFICERS LIABILITY WITH EMPLOYMENT PRACTICES LIABILITY OPTION AVAILABLE: We have several excellent markets for this coverage. Many enhancements are available including separate limits for the D & O and EPL coverage, Duty to Defend basis, Defense Outside the Limits, Optional Fiduciary Liability, 3 year prepaid policies and more. A separate application is required.

PROPERTY: We can write property, inland marine, and crime coverage on an admitted basis in most states. An ACORD application is required.

AUTO: Limits available up to $5,000,000. An ACORD application is required.

TYPES OF ELIGIBLE FACILITIES

Substance Abuse Programs includes Drug & Alcohol Treatment Centers, Halfway Houses for Recovering Substance Abusers, Methadone Maintenance Clinics, Detox Facilities

Residential Facilities includes Group Homes, Residential Care Homes, Residential Treatment Centers, Hospices

Outpatient Facilities includes Mental/Health Retardation Treatment Centers, Mental Health Counseling, Community Support Services and Associations for Retarded Citizens

Other Social Service Agencies - Sheltered Workshops, Adoption/Foster Care Agencies, Agencies for the Aging, Senior Citizens Centers, Home Care Services

By no means is this a comprehensive list of facilities eligible for our program. If you have any questions on eligibility, give one of our underwriters a call.

RULES WE MUST LIVE BY

•The application must be fully completed and signed by the insured prior to binding. If a question is not applicable, please indicate as such.

•Some coverages offered are with a Non-admitted Carrier. NIPC can handle the surplus lines filing for you in WA, AK, CA and CO. You are responsible for the surplus lines filing in every other state. Please provide the name and license number of the broker making the filing on the application.

•We must receive your written request to bind by the effective date. We cannot backdate coverage.

•The Professional/CGL and Excess/Umbrella policies carry a minimum earned premium of 25%. Flat cancellations aren't allowed after coverage is bound.

•100% of the premium is due in our office prior to the effective date.

1/00

THIS SUMMARY IS INTENDED AS A BRIEF OVERVIEW. THE COVERAGES ARE SUBJECT TO THE TERMS AND CONDITIONS FOUND IN THE POLICIES. FOR MORE DETAILS, DO NOT HESITATE TO GIVE US A CALL.

Reset

SOCIAL SERVICE AGENCY PROGRAM

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** **Describe** ____________

2. Your mailing address:
   ________________City and State____________ Zip_______
   Phone number (   )________ Contact Person:____________
   Effective Date of Coverage:____________ Webpage address ____________

   Please provide the addresses of all locations to be covered:

	STREET ADDRESS	CITY AND STATE	OCCUPANCY
1.			
2.			
3.			
4.			
5.			
6.			

3. How long has your agency been in operation?________ What is your annual budget?________

4. Please give us a complete percentage breakdown of your funding sources (total to equal 100%).

5. Of what organizations or associations are you a member? (Please avoid the use of acronyms)

YOUR STAFF

PHYSICIANS, PSYCHIATRISTS AND PSYCHOLOGISTS

NAME	SPECIALTY	HOURS WORKED PER WEEK	EMPLOYED OR CONTRACTED	DOES PHYSICIAN CARRY OWN MALPRACTICE COVERAGE?
				☐YES * ☐NO
				☐YES * ☐NO
				☐YES * ☐NO
				☐YES * ☐NO
				☐YES * ☐NO

*If YES, do you want coverage for physicians to apply on a primary or on an excess basis? ____________

OTHER STAFF

	Employees #Full Time	Employees #Part Time	Non-Employees (Volunteers/Consultants) #Full Time	Non-Employees (Volunteers/Consultants) #Part Time
RN's/LPN's				
Social Workers				
Residence Managers				
Counselors				
Others (specify)				
________				

6. Are you aware of any state, federal, local code or professional ethics violations by your agency or any of your employees? ☐ Yes ☐ No If Yes, please explain on a separate sheet.

7. Are you aware of any circumstances involving sex between any staff member and clients, former clients, or relatives thereof? ☐ Yes ☐ No If yes, please explain on a separate sheet.

8. Pre-Employment Activities: Are the following checked or verified? All references ______ Police Records ______ Educational Requirements __________ Licenses ________________

9. Do you maintain training programs for your staff? ☐ Yes ☐ No
Describe____

YOUR OPERATIONS

10. Please provide a brief description of your operations. (Attach any brochures or descriptive materials.)
____
____

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 for each facility. (see attachment PC159A)

B) **OUTPATIENT SERVICES**
Provide annual number of appointments for the following services. (Each client's visit should be counted as an appointment.) Include location #.

YES	NO		#of Appts.	Loc. #
☐	☐	Drug & Alcohol Treatment :Individual	______	______
☐	☐	Drug & Alcohol Treatment :Group	______	______
☐	☐	Drug & Alcohol Classes (DUI/DWI)	______	______
☐	☐	Mental Health Counseling: Individual	______	______
☐	☐	Mental Health Counseling: Group	______	______
☐	☐	MR Treatment Center	______	______
☐	☐	Cerebral Palsy Center	______	______
☐	☐	Rehabilitation Agency	______	______
☐	☐	Case Management (MH/MR/Comm. Support)	______	______
☐	☐	Training	______	______
☐	☐	Hospice (outpatient)	______	______
☐	☐	Family Skills Training	______	______

C) **Provide number of clients/children per day and number of days per year that facility operates and at what location:**

YES	NO		# of clients per day	# days per year	Loc. #
☐	☐	Headstart	______	______	______
☐	☐	Well Child Day Care	______	______	______
☐	☐	Day Camps for Mentally Ill_____ or Mentally Retarded _____	______	______	______
☐	☐	Sheltered Workshop/ Work Activity	______	______	______
☐	☐	Recreation Program	______	______	______
☐	☐	Day Schools	______	______	______
☐	☐	Senior Citizens Center	______	______	______
☐	☐	Adult/Senior Day Care	______	______	______

	YES	NO	
D)	☐	☐	Foster Placement Agency **If "YES" complete attached Foster/Adoption Placement Supplement (see attachment PC159B)**
E)	☐	☐	Adoption Placement Agency **If "YES" complete attached Foster/Adoption Placement Supplement (see attachment PC159B)**
F)	☐	☐	Home Care__________ Home Health Care__________ Respite Care__________ **Give total number of annual visits for each of the above services.**

	YES	NO		
G)	☐	☐	Miscellaneous Services:	
			Methadone Maintenance Clinic	Number of Licensed Slots______
			Meals on Wheels	Number of meals annually______
			Crisis Hotline Center	Number of Calls annually ______
			Referral Agency	Number of referrals annually______
			CASA (Court Appointed Special Advocates)	Number of cases assigned annually_____
H)	☐	☐	Other Services not described above	Annual Client Contacts or Appointments
			______________________	______________
			______________________	______________
			______________________	______________

12. Do you provide primary medical services? ☐YES ☐ NO If yes, please explain.

____

13. Does your agency recommend release, parole, or incarceration of clients? ☐YES ☐ NO
If yes, please explain.

____

14. Do you or any of your staff prescribe any medications? ☐YES ☐NO If yes, please provide a list of the medications, who prescribes them, for what purpose, and how they are secured.

15. Do you provide transportation for your clients? ☐YES ☐ NO If yes, please explain.

____

16. Are you licensed by the state(s) in which you operate? ☐YES ☐ NO
(Please attach 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.

____

17. Do you contract with any other facilities for additional beds? ☐ YES ☐ NO If yes, indicate the number or estimated number of beds and provide a copy of the contract. # of beds________

18. **COMMERCIAL GENERAL LIABILITY**
Would you like to include Commercial General Liability coverage? ☐YES ☐ NO If yes, please complete the following section:

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. footage)				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Heat Sensors	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Smoke Detectors	☐ ☐	☐ ☐	☐ ☐	☐ ☐
f. Fire Escapes or Exits	#________	#________	#________	#________
g. YEAR OF UPDATES IN CONSTRUCTION	Year:	Year:	Year:	Year:
	Yes No	Yes No	Yes No	Yes No
•plumbing	☐ ☐	☐ ☐	☐ ☐	☐ ☐
•wiring	☐ ☐	☐ ☐	☐ ☐	☐ ☐

COMMERCIAL GENERAL LIABILITY (continued)

19. Do you lease or sub-lease to others any portions 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 do you make sure the coverage is maintained?______________________________

20. Are there pools at any of your locations? ☐YES ☐ NO If Yes, how many? __________
Are there spas or hot tubs at any of your locations? ☐ YES ☐ NO If Yes, how many? __________
Are they used exclusively by your clients and/or staff? ☐YES ☐NO If No, Please describe the uses:
____
Are they secured when not in use? ☐YES ☐ NO Please describe security:
____
Are clients supervised while using the pool and/or spa? ☐YES ☐NO Please describe methods:
____

21. Will you be organizing or sponsoring any fund raising or special events during the next year? ☐YES ☐NO
If Yes, please describe each event including your role and the estimated amount of receipts.
______________________________ $__________
______________________________ $__________
______________________________ $__________

22. Do you participate in or supervise any sports activities for your clients? ☐YES ☐NO
If Yes, please describe. ______________________________

23. Do you anticipate any construction activity in the next year? ☐YES ☐ NO If yes, please describe and estimate the contract costs:______________________________
____

24. Do you sell goods or services to members of the public not including clients? ☐YES ☐NO
If yes, please describe the products and/or services and estimate the annual receipts for each.

Products__________________ Annual Receipts $__________
Services__________________ Annual Receipts $__________

25. Would you like us to include Employer's Non-Owned Automobile Liability coverage? ☐YES ☐NO
Do you require proof of insurance for employees driving their own auto on agency business? ☐YES ☐NO
Do you check motor vehicle records? ☐YES ☐NO

26. 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)
____

27. 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 ADDITIONAL INSUREDS

Insurable Interest- check box that applies

Name:________________ ☐ Funding/Placement ☐ Landlord ☐ Contract/ Services ☐ Other

Address:________________ Describe______

____

Name:________________ ☐ Funding/Placement ☐ Landlord ☐ Contract/ Services ☐ Other

Address:________________ Describe______

____

Name:________________ ☐ Funding/Placement ☐ Landlord ☐ Contract/ Services ☐ Other

Address:________________ Describe______

____

YOUR MOST RECENT INSURANCE HISTORY

LINE	COMPANY	LIMITS	PREMIUM	DEDUCTIBLE	EXPIRATION DATE	RETROACTIVE DATE
Professional Liability						
General Liability						
Excess and/or Umbrella						

28. If you haven't purchased coverage before, please explain. ________________

29. Is your expiring professional liability coverage on a claims made policy? ☐ 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.

30. Has any carrier cancelled or refused coverage for your agency? ☐ YES ☐ NO
If yes, please explain. ________________

31. What limit of liability do you require? ________________

CLAIM INFORMATION

32. Have you had any claims and/or incidents that may give rise to a claim in the past five years?
☐ YES ☐ NO
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.

33. Please describe your procedures when reporting potential incidents to the proper authorities.
____

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 the insurance.

________________________ ________________________________

Date Signed Signature of Applicant

____

Please print Name and Title

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

THE PRODUCER WARRANTS THAT ALL OF THE INSURANCE REQUIREMENTS OF THE APPLICANT'S HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH, INCLUDING MAKING THE SURPLUS LINES FILING AND SUBMITTING THE SURPLUS LINES FEES AND TAXES, WHERE APPLICABLE.

________________________ ________________________________

Date Signed **Signature of Producer submitting to NIPC**

❑Retailer ❑Wholesaler

Producing Agency submitting to NIPC:____

Address: ____

____

Telephone: (_____)__________________ **Fax:** (_____)______________

SURPLUS LINES BROKER: ____________________________________

SURPLUS LINES LICENSE NUMBER: ____________________________________

(FLORIDA BROKERS: FEIN NUMBER): ____________________________

ALL QUESTIONS MUST BE COMPLETED AND ALL SIGNATURES AND APPLICABLE INFORMATION PRESENT BEFORE A QUOTE CAN BE OFFERED.

SUPPLEMENTAL RESIDENTIAL FACILITY QUESTIONNAIRE
PLEASE ATTACH A COPY OF FACILITY LICENSE AND MOST RECENT STATE INSPECTION

1. Location number________ Name of the facility ______________________________
(if different from your agency name)

2. Which of the following best describes this facility:
☐ Substance Abuse Treatment
☐ Sober Living/Halfway House
☐ Emergency or Homeless Shelter
☐ Supervised or Transitional Living
☐ Detox % Medical detox: ____ % Non-med. ______
☐ Group Home/Therapeutic Care
☐ Assisted Living Facility

3. Licensed bed capacity______________ Current Occupancy ______________

4. Please indicate the staffing at this facility:

Discipline	1st Shift	2nd Shift	3rd Shift
Psychiatrists (M.D.s)	________	________	________
Other Physicians (M.D.s)	________	________	________
Psychologists (Ph.Ds)	________	________	________
Social Workers/Counselors	________	________	________
Residence Managers	________	________	________
Residential Aid/Caregiver	________	________	________
Others (specify) ____________	________	________	________

5. Age Group of Clients residing at this facility: __________ Average length of stay ______________

6. Is the facility Room and Board only? ☐ Yes ☐ No

7. Do your residents have mental disabilities? ☐ Yes ☐ No
If Yes, Please describe. ______________________________
Mild: __________ Moderate: ___________ Severe: ____________
Any residents with depressive disorder? ☐ Yes ☐ No
Schizophrenia ________ Paranoia ______ Psychotic ________
Number of residents that are non-ambulatory: ________________

8. Does this facility have 24 hour on-site staff? ☐ Yes ☐ No

9. Is this a lock-up facility for any of your residents? ☐ Yes ☐ No If yes, please describe the security or provide a property inspection report.______________________________
____

10. What is the water temperature set at? __________

11. What measures are taken to monitor client activities?______________________________
Do you have sign out procedures? ☐ Yes ☐ No If No, are there alarms on doors? ☐ Yes ☐ No

12. Are there any animals on premises? ☐ Yes ☐ No If Yes, please describe.______________
Are they restrained or do they interact with clients? ______________________________

ADOPTION AND FOSTER CARE PLACEMENT
AGENCY SUPPLEMENTAL APPLICATION

ADOPTION PLACEMENT AGENCIES:

IMPORTANT- Please attach copies of all homestudy apps and information to prospective families, placement guidelines and procedures.

1. Estimated number of adoption placements expected for the upcoming year ________________.
   % Domestic Placements __________ % International __________

2. Are both birth parents contacted prior to all adoption proceedings? ☐ Yes ☐ No

3. Do you have an attorney on staff? ☐Yes ☐No If Yes, provide the name of the Legal E & O carrier and limits carried. ______________________________

4. Do you perform homestudies for clients other than your prospective adoptive parents? ☐Yes ☐No
   If Yes, provide estimate of the number of these homestudies performed. ________________

For International Adoptions:

5. Please list countries of origin: ______________________________
   ____

FOSTER PLACEMENT AGENCIES:

IMPORTANT– Please attach
Current list of foster families.
Copies of placement procedures, family selection and training guidelines.

Using your most previous calendar or fiscal year, please provide the following:

1. a). Number of children in foster care at beginning of year + ________
   b). New placements made + ________
   c). Number of exiting placements - ________
   d) Current number of children in care = ________

2. Estimated number of new placements for upcoming year. ________

3. Estimated number of exiting placements in upcoming year. ________

4. How often do you counsel or visit child or foster family? ____________________

5. Current number of certified foster families. __________

6. Average number of cases per caseworker. ____________