



8722 S. Harrison St. Sandy, UT 84070  
P.O. Box 4439 Sandy, UT 84091  
877-585-2853 • Fax 877-585-2854

**SOCIAL  
SERVICE  
AGENCIES**

**General Information**

Proposed Effective Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

Business Telephone Number: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Physical Location of Business (if different): \_\_\_\_\_

Population within 50 miles: \_\_\_\_\_

**Other Locations Used:**

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list any other names the business is or has been known by: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Producer No.: \_\_\_\_\_ Producer's Name: \_\_\_\_\_

Producer's E-mail: \_\_\_\_\_

Detailed description of business activities (specifically, and by location): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is this a new business?  Yes  No If no, how many years have you been in business? \_\_\_\_\_

Applicant is:  Individual  Corporation  Partnership  Joint Venture

Other (please describe): \_\_\_\_\_

Annual Payroll: \$ \_\_\_\_\_

Total Number of Employees: \_\_\_\_\_ Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services?  Yes  No

If yes, please tell us:

Employee Name: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Business Telephone No.: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_ Years with Company: \_\_\_\_\_

Employee's Responsibilities: \_\_\_\_\_

**1. Insurance History**

Who is your current insurance carrier (or your last if no current provider)? \_\_\_\_\_

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

|                 | Coverage: | Coverage: | Coverage: |
|-----------------|-----------|-----------|-----------|
| Company Name    |           |           |           |
| Expiration Date |           |           |           |
| Annual Premium  | \$        | \$        | \$        |

Has the Applicant or any predecessor or related person or entity ever had a claim?  Yes  No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?  Yes  No

If the standard markets are declining placement, please explain why: \_\_\_\_\_  
 \_\_\_\_\_

**2. Desired Insurance**

**Limit of Liability - Professional Liability Coverage:**

| Per Act/Aggregate        |                       | Per Person/Per Act/Aggregate |                                 |
|--------------------------|-----------------------|------------------------------|---------------------------------|
| <input type="checkbox"/> | \$50,000/\$100,000    | <input type="checkbox"/>     | \$25,000/\$50,000/\$100,000     |
| <input type="checkbox"/> | \$150,000/\$300,000   | <input type="checkbox"/>     | \$75,000/\$150,000/\$300,000    |
| <input type="checkbox"/> | \$250,000/\$1,000,000 | <input type="checkbox"/>     | \$100,000/\$250,000/\$1,000,000 |
| <input type="checkbox"/> | \$500,000/\$1,000,000 | <input type="checkbox"/>     | \$250,000/\$500,000/\$1,000,000 |
| <input type="checkbox"/> | Other: _____          | <input type="checkbox"/>     | Other: _____                    |

**Self Insured Retention (SIR):**  \$1,000 (Minimum)  \$1,500  \$2,500  \$5,000  \$10,000

**3. Business Activities**

1. What organizations or associations is applicant a member of? \_\_\_\_\_  
 \_\_\_\_\_
2. Is applicant accredited by any organizations:  Yes  No  
 If yes please identify: \_\_\_\_\_
3. Applicant is licensed by: \_\_\_\_\_
4. Date of your last survey: \_\_\_\_\_
  - a. Were any deficiencies found?  Yes  No  
 If yes, please attach an explanation.
5. Annual budget: \$ \_\_\_\_\_
6. Primary funding provided by: \_\_\_\_\_
7. Please include the following information for all locations:

| LOC. # | ADDRESS | NATURE OF SERVICE PROVIDED | INTEREST | NUMBER OF STORIES |
|--------|---------|----------------------------|----------|-------------------|
| 1.     |         |                            |          |                   |
| 2.     |         |                            |          |                   |
| 3.     |         |                            |          |                   |
| 4.     |         |                            |          |                   |
| 5.     |         |                            |          |                   |

8. Please describe the types of services you provide (if there is a service listed that you do not provide, enter "None"):

| SERVICES PROVIDED          | # OF CLIENTS | # OF VISITS ANNUALLY | # OF BEDS | AVE. LENGTH OF STAY |
|----------------------------|--------------|----------------------|-----------|---------------------|
| Mental Health Counseling   |              |                      |           |                     |
| Family Counseling          |              |                      |           |                     |
| Substance Abuse Counseling |              |                      |           |                     |
| Detox                      |              |                      |           |                     |
| Special Schools            |              |                      |           |                     |
| Head Start                 |              |                      |           |                     |
| Referral Services          |              |                      |           |                     |
| Respite Care               |              |                      |           |                     |
| Adult Day Care             |              |                      |           |                     |
| Employment Training        |              |                      |           |                     |
| Medical Clinic             |              |                      |           |                     |
| Child Day Care             |              |                      |           |                     |
| Crisis Hotline             |              |                      |           |                     |
| Foster Care                |              |                      |           |                     |
| Adoption                   |              |                      |           |                     |
| Electro Shock              |              |                      |           |                     |
| Aversion Therapy           |              |                      |           |                     |
| Rehabilitation             |              |                      |           |                     |
| Hospice                    |              |                      |           |                     |
| Halfway House              |              |                      |           |                     |
| Other:                     |              |                      |           |                     |
| Other:                     |              |                      |           |                     |

9. Describe the population served: \_\_\_\_\_  
 \_\_\_\_\_

10. Age group: \_\_\_\_\_

11. Describe any recreational facilities or activities provided: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Please provide the following information about your staff:

| PROFESSION     | EMPLOYED OR CONTRACTED? | FULL TIME OR PART TIME? |
|----------------|-------------------------|-------------------------|
| Nurses, L.P.N. |                         |                         |
| Nurses, R.N.   |                         |                         |
| Psychologists  |                         |                         |
| Counselors     |                         |                         |
| Social Workers |                         |                         |
| Administrators |                         |                         |
| Volunteers     |                         |                         |
| Other:         |                         |                         |

13. Physicians

| NAME                                |  |  |  |
|-------------------------------------|--|--|--|
| SPECIALTY                           |  |  |  |
| BOARD CERTIFIED OR ELIGIBLE?        |  |  |  |
| EMPLOYED OR CONTRACTED?             |  |  |  |
| HOURS PER WEEK                      |  |  |  |
| DOES PHYSICIAN CARRY OWN INSURANCE? |  |  |  |
| LIMITS                              |  |  |  |

14. If physicians carry their own insurance, do you obtain certificates of insurance?  Yes  No

15. Are physicians to be covered under this policy?  Yes  No

**Risk Management**

16. Is there a formal written risk management program in place?  Yes  No

17. Are drugs prescribed or administered?  Yes  No

18. Where are medications stored? \_\_\_\_\_

19. Are complete records kept on all patients?  Yes  No

20. Do you require signed release forms for release of patients records?  Yes  No

21. Are owned vehicles used to transport clients?  Yes  No

**REPRESENTATIONS AND WARRANTIES**

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

Applicant:

Agent/Broker:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name