REQUESTED COVERAGE – ADOPTION AGENCY AND FOSTER PLACEMENT

☐ Requesting Professional Liability:
Requested Retro Date: ___________

<table>
<thead>
<tr>
<th>Professional Liability Limits</th>
<th>Professional Liability Deductible</th>
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</thead>
<tbody>
<tr>
<td>$100,000 / $300,000</td>
<td>$1,000,000 / $1,000,000</td>
</tr>
<tr>
<td>$200,000 / $600,000</td>
<td>$1,000,000 / $2,000,000</td>
</tr>
<tr>
<td>$250,000 / $750,000</td>
<td>$1,000,000 / $3,000,000</td>
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<tr>
<td>$500,000 / $1,500,000</td>
<td>Other: _______________</td>
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☐ Requesting General Liability:
Requested Retro Date: ___________ or ☐ Occurrence Based Coverage

<table>
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<tr>
<th>General Liability Limits</th>
<th>General Liability Deductible</th>
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<tbody>
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<td>$100,000 / $300,000</td>
<td>$1,000,000 / $1,000,000</td>
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<tr>
<td>$200,000 / $600,000</td>
<td>$1,000,000 / $2,000,000</td>
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<tr>
<td>$250,000 / $750,000</td>
<td>$1,000,000 / $3,000,000</td>
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<tr>
<td>$500,000 / $1,500,000</td>
<td>Other: _______________</td>
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☐ Requesting Employee Benefits Liability (supplement required):
Requested Retro Date: ___________

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<th>Employee Benefits Liability Limits</th>
<th>Employee Benefits Liability Deductible</th>
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<tr>
<td>$200,000 / $600,000</td>
<td>$1,000,000 / $2,000,000</td>
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<tr>
<td>$250,000 / $750,000</td>
<td>$1,000,000 / $3,000,000</td>
</tr>
<tr>
<td>$500,000 / $1,500,000</td>
<td>Other: _______________</td>
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</tbody>
</table>

☐ Requesting Non-Owned Auto Liability:

<table>
<thead>
<tr>
<th>Non-Owned Auto Liability Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100,000</td>
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<tr>
<td>$200,000</td>
</tr>
<tr>
<td>$250,000</td>
</tr>
<tr>
<td>Other: _______________</td>
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</tbody>
</table>

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.
ADOPTION AGENCY AND FOSTER PLACEMENT APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state “N/A”.
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days
  - Copy of contract between agency and adoptive, birth or foster parents

<table>
<thead>
<tr>
<th>GENERAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Full name of Applicant (Including DBA’s) ____________________________</td>
</tr>
<tr>
<td>2. Mailing Address: ____________________________________________________</td>
</tr>
<tr>
<td>STREET          CITY          COUNTY          STATE          ZIP</td>
</tr>
<tr>
<td>3. Location Address(es): Check here if same as mailing: ☐</td>
</tr>
<tr>
<td>(1) __________________________</td>
</tr>
<tr>
<td>(2) __________________________</td>
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<tr>
<td>(3) __________________________</td>
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<tr>
<td>(4) __________________________</td>
</tr>
</tbody>
</table>

Attach Additional Pages as Needed

4. Website Address: www. ____________________________ 5. Telephone: ____________________________

6. Inspection/Risk Management Contact Name: ____________________________

7. Inspection/Risk Management Contact E-mail: ____________________________

8. Date Established ________________ Years under current management ____________
9. Applicant is a:
   - Individual
   - Professional Associations
   - Corporation
   - Partnership
   - LLC
   - Joint Venture
   - Other: ____________________________________

10. Enterprise is:
    - For Profit
    - Not For Profit

11. Is this entity owned by, associated with or controlled by any other entity?  
    Yes ☐ No ☐  
    If yes, please provide details: ________________________________________________________________  
                                ________________________________________________________________  
                                ________________________________________________________________

12. Please indicate type of service:  
    - Adoption Agency
    - Foster Placement Agency
    - Other, please describe: ________________________________________________________________

13. Please describe in detail the nature of the applicant’s operation and types of services rendered.  
    ________________________________________________________________  
    ________________________________________________________________  
    ________________________________________________________________

14. Please state sources and amounts of total revenue:  
    Source                Last 12 months    Next 12 months
    Charitable contributions  $______________  $______________  
    Government Funding       $______________  $______________  
    Fee for services         $______________  $______________  
    Other – specify:         $______________  $______________  
    Total Gross Revenue      $______________  $______________

15. Does the applicant maintain any beds for overnight occupancy?  
    Yes ☐ No ☐  
    If yes, please provide total number ________ (youth residential supplement will be required)

16. Are you accredited?  
    Yes ☐ No ☐  
    If yes, by whom? ________________________________  
    Please attach copy of state license.

17. Do you have a written procedure for dealing with sexual abuse?  
    Yes ☐ No ☐
18. Please provide details on the background checks performed by the Applicant on foster or adoptive families prior to approval of homes. 

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

19. Please complete the following:

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>Semi-Open</th>
<th>Closed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Adoptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In past 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of projected</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In next 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Please provide the percentage (%) of children placed from the following:
   a. Domestic/State Agencies ___________________
   b. Foreign Operations ______________________
   c. Private Placements ______________________
   d. Other (Specify): _________________________

21. Are foreign adoptions only offered through Hague Convention countries? Yes ☐ No ☐
   If no, please provide name of the country and number of placements anticipated:
   ___________________________          ____________________          ____________________
   ___________________________          ____________________          ____________________

22. Are all children adopted from foreign countries screened for disease, illness, mental illness etc.? Yes ☐ No ☐

23. Please provide a copy of the applicant’s contract signed by the adoptive parents.

24. Please indicate:
   Number of foster placements performed this year? ________________________
   Number of foster placements projected for the coming year ________________________

25. How many foster homes are utilized? ________________________
   a. Are all foster homes licensed by applicable state and/or local authorities? Yes ☐ No ☐
   b. If no, who licenses the foster homes?

   __________________________________________________________

26. Maximum number of foster children placed in one home at any one time? ________________________

Page 4 of 11
27. How often are visits made by caseworkers to each foster home? ____________________________

28. How many visits in the last 12 months have resulted in loss of certification or license? ______________

29. What is the average social workers case load? One caseworker to _____ children.

30. Please provide the percentage (%) of children placed from the following:
   a. Well Child __________________________
   b. Emotionally Disturbed ________________
   c. Mentally Retarded ____________________
   d. Other (Specify): ____________________

31. What is the total number of hours of training for each foster family PRIOR to placement of the first foster child? ______________

32. Are foster family criminal records checked prior to approval of homes? Yes □ No □

33. Are foster parents or foster households who have criminal records, or any history of physical or sexual abuse immediately disapproved or de-licensed? Yes □ No □
   If no, please explain: __________________________________________________________

**STAFF**

34. Please indicate the number of employed and contracted staff by type:

<table>
<thead>
<tr>
<th>Profession</th>
<th>Employed</th>
<th>Contracted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Time</td>
<td>Part Time</td>
</tr>
<tr>
<td>Administrators</td>
<td></td>
<td></td>
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<tr>
<td>Counselors</td>
<td></td>
<td></td>
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<tr>
<td>Psychologists</td>
<td></td>
<td></td>
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<tr>
<td>Social Workers</td>
<td></td>
<td></td>
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<tr>
<td>Therapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students/Volunteers</td>
<td></td>
<td></td>
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<tr>
<td>Other (Specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
35. Are all above individuals licensed in accordance with applicable state and federal regulations?
   Yes ☐ No ☐

36. Do you require contracted staff to carry their own professional liability insurance?
   Yes ☐ No ☐
   If yes, what limits do they carry? ________________

37. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:

   - ☐ Check of educational background, or residency program, when applicable.
   - ☐ Check of previous employers (☐ In writing ☐ By Telephone)
   - ☐ Criminal background check (☐ STATE ☐ FEDERAL)
   - ☐ Drug / Alcohol / Abuse Screening (circle all that are used)
   - ☐ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
   - ☐ Require information on any professional liability or work-related claim that has previously been made against any individual?

GENERAL LIABILITY - complete only if you are requesting GL coverage

38. Building Description

<table>
<thead>
<tr>
<th>Buildings/Wings</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
</tr>
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<tbody>
<tr>
<td>Type of Construction:</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<tr>
<td>No. of Stories:</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Square Footage:</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Date Built:</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Smoke detectors:</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Local/Central station fire alarm:</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Sprinkler System:</td>
<td>☐ Yes ☐ No ☐ Partial</td>
<td>☐ Yes ☐ No ☐ Partial</td>
<td>☐ Yes ☐ No ☐ Partial</td>
<td>☐ Yes ☐ No ☐ Partial</td>
</tr>
</tbody>
</table>

39. Do any of the Applicant’s locations have any (explain any “yes” answers on page 8):
   a. Exposure to flammables, explosives, chemicals?
   Yes ☐ No ☐
   b. Catastrophe exposure?
   Yes ☐ No ☐
   c. Exposure to radioactive materials?
   Yes ☐ No ☐

40. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? If Yes, answer complete a supplemental claims form for each.
   Yes ☐ No ☐

41. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? If Yes, complete a supplemental claims form for each.
   Yes ☐ No ☐
### 42. Please list professional liability insurance carried for each of the past five years.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Dates covered</th>
<th>Limits of Liability Per claim/ agg</th>
<th>Deductible</th>
<th>Premium</th>
<th>Retroactive date</th>
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</thead>
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### 43. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Dates covered</th>
<th>Limits of Liability Per claim/ agg</th>
<th>Deductible</th>
<th>Premium</th>
<th>Occurrence or Claims – Made?</th>
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If the current expiring GL policy is claims- made what is the retroactive date? _____________

### Provide details for all “yes” answers to questions 43-50 on page 8 or attach additional pages as needed.

44. Has the applicant or any of its employees ever had any professional license or license to prescribe and/ or dispense narcotics limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency?  
   Yes ☐ No ☐

45. Has the applicant or any of its employees ever been charged with, or convicted of a crime other than minor traffic violation?  
   Yes ☐ No ☐

46. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness?  
   Yes ☐ No ☐

47. Has any insurance company ever rescinded, cancelled, non-renewed, or declined any similar insurance for the applicant? If yes, please provide a detailed explanation.  
   Yes ☐ No ☐
48. Has any claims or suit ever been made against the applicant OR any other person proposed for this insurance? *(Complete Supplemental Claims form for Each.*)

Yes ☐ No ☐

49. Have there been any claims or do you have knowledge of information which might reasonably be expected to give rise to a claim of physical abuse or molestation?

Yes ☐ No ☐

50. Is the applicant or any person proposed for this insurance aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? *(Complete Supplemental Claims form for Each.*)

Yes ☐ No ☐

51. Is the applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance or records request from any attorney which may result in a claim or suit? *(Complete Supplemental Claims form for Each.*)

Yes ☐ No ☐

SUPPLEMENTAL INFORMATION
Use the remainder of this page as needed or to address questions referenced within the application

________________________________________________________________________
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Page 8 of 11
FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: 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, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant’s acceptance of the company’s quotation is required prior to binding coverage and policy issuance.

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

Applicant: ___________________________ Title: ___________________________

FEIN #: ____________________________

Applicant’s Signature: ___________________________ Date: ___________________________

Agent / Broker Name: ______________________________________________________
If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

| Name of Patient: ___________________________ | Age: _______ | Sex: ______ |
| Incident □ | Claim □ |
| Date reported to insurance company: ____________ |
| Name of insurance company: ___________________________ |
| Date of incident and your treatment: ____________________________________________________ |
| Allegations / Circumstances: ________________________________________________________________ |
| Additional Defendants: ____________________________________________________________ |
| What is the present condition of the patient? _______________________________________________ |

**STATUS OF CLAIM**

- [ ] Suit threatened, no action taken
- [ ] Suit filed but dropped by claimant
- [ ] Summary judgment in your favor
- [ ] Suit settled out of court
  - a. Date claim paid: ____________
  - b. Amount paid: $ ____________
  - c. Did you want to settle? [ ] Yes [ ] No
- [ ] Court outcome in YOUR favor:
  - [ ] Jury verdict
  - [ ] Directed verdict
- [ ] Court outcome in favor of plaintiff:
  - [ ] Jury verdict
  - [ ] Directed verdict
- [ ] Amount of loss payment: $ ____________

**Unresolved/Open**

- [ ] Awaiting mediation
- [ ] Awaiting court action
- Reserve amount: $ ____________

Name and address of the attorney assigned to your case: ________________________________

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?  
- [ ] Yes [ ] No

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Signature: ___________________________ Date: ____________

Printed Name: ______________________