

APPLICATION FOR PROFESSIONAL &
GENERAL LIABILITY COVERAGE

YOUTH CORPS

National Association of Service and Conservation Corps

Effective Date Requested: _____ Date Quotation Desired: _____

Limits: \$100,000/200,000 \$1,000,000/\$1,000,000 \$1,000,000/3,000,000 \$2,000,000/6,000,000

Are you a member of NASCC? Yes No

GENERAL INFORMATION

1. Applicant: _____

2. Mailing Address: _____
City _____ State _____ Zip _____

3. Person to Contact: Name _____ Title _____
Telephone Number: _____

4. Year business started or date of incorporation _____

5. Annual Revenue/Budget: \$ _____ Gross sales, if any: \$ _____

6. Major funding sources: _____

7. Number of locations: _____

List Each Location:

Sq. Ft. at Each Location:

a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____
e.	_____	_____

PRIOR INSURANCE

Does the Applicant carry Professional Liability Insurance now? Yes No
General Liability Insurance? Yes No

If yes, describe below for both lines of coverage:

Insurer: GL _____
PL _____

Occurrence Form: Yes No
Claims Made: Yes No

Limit of Liability: GL \$ _____ PL \$ _____

Annual Premium GL \$ _____ PL \$ _____

If Yes advise retroactive date: _____

Inception Date: _____ Expiration Date _____

Has the prior carrier indicated an intent not to renew? Yes No

If yes, please explain: _____

Is Agent the current broker of record? Yes No

PAST CLAIM ACTIVITIES

Describe all previous lawsuits, claims or incidents resulting in complaints made against the Applicant involving any allegation of a professional nature during the past five years including date of loss and amount paid or reserved.

Are you aware of any facts or circumstances or any actual or alleged act, error or omission which may result in claims being made against the Applicant or its employees or its volunteers? Yes No

If yes, please explain: _____

PROFESSIONAL LIABILITY

- Foster Care
 Child Placement
 Adoptions
 Treatment of violent or sex offenders
 Alternative Incarceration
 Public Health Department

PROFESSIONAL STAFF

Please provide a breakdown on the following:

Schedule of Non-physician Staff	Number		Schedule of Non-physician Staff	Number	
	Full Time	Part Time		Full Time	Part Time
Executive Director			Social Workers		
Administration			Students		
Counselors			Volunteers		
Psychologists			Clerical		
Nurses, R.N.			Physical Therapists		
Nurses, L.P.N.			Others - Identify		

Full Time = More than 20 hours per week

Part Time -- Less than 20 hours per week

SUPPLEMENTAL QUESTIONS:

- Is this applicant: Local State National
- Number of corps members in program? _____ # full-time _____ # part-time
- Are corps members: Employees Contractors of Applicant
- Are any adjudicated youth amongst the corps members? Yes No
If yes, describe: _____

- | | | |
|---|--------------------------|--------------------------|
| 5. Describe services provided: | Yes | No |
| Work Projects | <input type="checkbox"/> | <input type="checkbox"/> |
| Conservation or Environmental Recycling | <input type="checkbox"/> | <input type="checkbox"/> |
| Victim Assistance/Disaster Relief | <input type="checkbox"/> | <input type="checkbox"/> |
| Human Services | <input type="checkbox"/> | <input type="checkbox"/> |
| Public Safety | <input type="checkbox"/> | <input type="checkbox"/> |
| Education | <input type="checkbox"/> | <input type="checkbox"/> |
| Design | <input type="checkbox"/> | <input type="checkbox"/> |
| Construction of Buildings | <input type="checkbox"/> | <input type="checkbox"/> |
| Construction of Play Structures | <input type="checkbox"/> | <input type="checkbox"/> |
| Weatherization | <input type="checkbox"/> | <input type="checkbox"/> |
| Demolition | <input type="checkbox"/> | <input type="checkbox"/> |
| Rehabilitation of Buildings | <input type="checkbox"/> | <input type="checkbox"/> |
| Renovation of Buildings | <input type="checkbox"/> | <input type="checkbox"/> |
| Landscaping | <input type="checkbox"/> | <input type="checkbox"/> |
| Asbestos, Radon or Lead Abatement | <input type="checkbox"/> | <input type="checkbox"/> |
| Wetland Mitigation | <input type="checkbox"/> | <input type="checkbox"/> |
| Mentoring of Children | <input type="checkbox"/> | <input type="checkbox"/> |

TRAINING

- Please attach a training manual or briefly summarize training: _____

Required to participate in programs.

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| a. Is training given prior to engaging in work projects? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Is training done exclusively on job? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Is training done by employees? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Is training done by contractors? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are certificates of insurance required on all contractors? | <input type="checkbox"/> | <input type="checkbox"/> |

2. Do you provide educational services other than job training? Yes No
If yes, describe: _____
3. Describe the background of Instructors and Supervisors: _____
- | | Yes | No |
|-----------------------|--------------------------|--------------------------|
| a. References checked | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Method of referral | | |
| • Schools | <input type="checkbox"/> | <input type="checkbox"/> |
| • Public Agencies | <input type="checkbox"/> | <input type="checkbox"/> |
| • Private Sector | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Other: _____ | | |

SEXUAL ABUSE

1. Does your staff's (paid and volunteer) employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses? Yes No
2. a. Does your state permit you to do criminal background investigations on prospective employees? Yes No
b. If Yes, do you routinely request and receive such background investigations? Yes No
3. Do you verify employment-related references? Yes No If Yes, In person By telephone
4. Do you conduct a personal interview? Yes No
5. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a Client/child reports someone molested him/her? Yes No
6. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? Yes No
7. Do you have a written crisis management plan for dealing with staff personnel, victim, parents, authorities, and media if you have an incident of abuse? Yes No If Yes, attach copy.
8. a. Have you ever had an incident that resulted in an allegation of sexual abuse? Yes No
b. Was a claim made against you? Yes No
c. Was case settled? Yes No
d. Taken to trial? Yes No
e. How much money was paid as damages to the victim? _____
f. Was a formal investigation conducted by your licensing agency? Yes No
If Yes, provide a copy of the details.

DECLARATION AND SIGNATURE

The Applicant represents to the best of his/her knowledge and belief that the statements set forth herein are true and include all material information.

The Applicant further represents that if the information supplied on this application changes between the date of its application and the inception date of the policy period, he/she will immediately notify GBT Insurance Agency Solutions LLC of such change. Signing of this application does not bind GBT Insurance Agency Solutions LLC to offer nor the Applicant to accept insurance, but it is agreed that this application and any attachments thereto shall be the basis of the insurance and the policy will be issued in reliance on those representations.

Signature _____ Date _____
Principal, Partner or Officer

The following statements are required by the regulations of the following state Insurance Departments. It is a requirement of certain states that this signed statement is attached to the policy. Please read the statement applicable to your state and sign where indicated.

CALIFORNIA APPLICANTS: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Applicant Signature Date _____

FLORIDA APPLICANTS: PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Applicant Signature Date _____

KENTUCKY APPLICANTS: 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 CONCERNING FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Applicant Signature Date _____

MINNESOTA APPLICANTS: A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

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.

Applicant Signature Date _____

NEW YORK APPLICANTS: 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 CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIM, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

Applicant Signature Date _____

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.

Applicant Signature Date _____

OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Applicant Signature Date _____

UTAH APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT UNDERWRITING INFORMATION, FILES OR CAUSES TO BE FILED A FALSE OR FRAUDULENT CLAIM FOR DISABILITY COMPENSATION OR MEDICAL BENEFITS, OR SUBMITS A FALSE OR FRAUDULENT REPORT OR BILLING FOR HEALTH CARE FEES OR OTHER PROFESSIONAL SERVICES IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Applicant Signature Date _____