

SOCIAL SERVICES (PROFESSIONAL) INSURANCE APPLICATION

Application Instructions

- A. Please type or complete the application in ink.
- B. If additional space is needed, please use your firms letterhead.

Instant Indication

A. Applicant Information

1. Applicant Company Name: _____
DBA: _____
2. Address 1: _____
Address 2: _____
3. City: _____ State: _____ Zip Code: _____
4. Effective Date: _____
5. Expiration Date: _____

B. Operations

1. Category (*Please circle one*):
Social Service Agencies
Substance Abuse Programs
Residential And Inpatient Care Facilities
Adoption And Foster Care Agencies
Elderly Care Services
Other _____
2. Type (*Depends on category selected*):
***PLEASE CIRCLE TYPE OF SOCIAL SERVICE AS WELL AS PROVIDE THE NECESSARY QUALIFYING DATA**
Social Service Agencies
Big Brother / Big Sister (# of children) _____
Crisis Centers (# of visits) _____
Crisis Hotline (# of calls annually) _____
Day Care Centers _____
Day Schools _____

Hospice – Outpatient (# of visits) _____
Mental Health Day Care – Part Hospital _____
Mental Health Day School _____
Developmentally Disabled / Cerebral Palsy Cntrs (# of visits) _____
Outpatient Counseling (# of visits) _____
Recreation Programs _____
Referral Agencies (# of referrals) _____
Sheltered Workshops And Work Activities (# of visits) _____
Training (Please describe and include # of clients) _____

Substance Abuse Programs

Alcohol / Drug Counseling (Outpatient) (# of visits) _____
Detox (Inpatient) (# of beds) _____
Detox (Non-medical) (# of beds) _____
DUI Classes (# of client contacts) _____
Methadone Maintenance (# of visits) _____

Residential And Inpatient Care Facilities

Contracted Beds (# of beds) _____
Group Home (3+ month w/ other services) (# of beds) _____
Group And Residential Homes (# of beds) _____
Halfway House – Inpatient (# of beds) _____
Homes For Battered (Refugees) (# of beds) _____
Hospice (# of beds) _____
Inpatient Mental Health (# of beds) _____
Residential Treatment – MH/MR (# of beds) _____
Supervised Living Arrangement (# of beds) _____

Adoption And Foster Care Agencies

Adoption: Child / Adolescent (Annual) (# of placements) _____
Adoption: Adult (# of placements) _____
Adoption: Aged / Elderly (# of placements) _____
Foster Care: Child/Adolescent (Annual) (# of placements) _____
Foster Care: Adult (# of placements) _____
Foster Care: Aged / Elderly (# of placements) _____

Adoption Counseling (# of visits) _____

Foster Care Counseling (# of visits) _____

Respite Care (# of visits) _____

Elderly Care Services

Agency For Aged / Senior Citizens (# of visits) _____

Home Health (# of visits) _____

Meals On Wheels (# of meals) _____

3. Does your state or local authorities require you to be licensed for any category/type chosen? YES/NO

If 'YES', please answer the following:

Do you have a current, valid license for all categories/types chosen? YES/NO

C. Additional Operations

1. Number of Employees

Psychiatrists (Full Time, Part Time, Volunteer, Consulting): _____

Psychologist (Full Time, Part Time, Volunteer, Consulting): _____

2. Applicant Is *(Please circle one)*: Non Profit Government For Profit Other

3. Does anyone applying for insurance under this policy use sex or rebirthing as a form of therapy, or believe that it is valid or appropriate? YES/NO

If 'YES', please explain:

4. Years Operational:

Who Is Filing The Surplus Lines Taxes? _____

Description of Operation: _____

Does the applicant include any of the following items below: YES/NO

- * "Outward Bound" type programs (where this is their sole source of revenue, provided to outside organizations)
- * Home Healthcare - accounting for more than 15% of services
- * Transportation services
- * Any risk required to make ICC or PUC filings

- * Ambulance Services
- * Correction oriented/related risks or alternative incarceration programs
- * Churches
- * Juvenile detention facilities or programs (Bootcamps & Lockdown facilities)
- * Cardiac rehabilitation agencies
- * Nursing Homes
- * Assisted Living facilities
- * Private industry councils
- * Standalone day care or over night camps unless part of other services - more than 15% of services
- * EMS/First Aid/Emergency Care Services
- * Acute Psychopathic residential institutions - accounting for more than 15% of services
- * Abortion Clinics/Birthing Centers
- * Level III.7 & Level IV Medical Detoxification rehabilitation facilities
- * All Physicians and Lawyers professional liability (except psychiatrists employed by the agency)
- * Any Clean Needle or Needle Exchange Program
- * Construction when part of organization's services or programs

D. Policy Limits

1. **Limits of Liability:** _____

Deductible: _____

E. Coverages & Endorsements

1. **Physical Abuse and Sexual Misconduct: YES/NO**

If 'YES', what is the desired limit: _____

**Please Note: TRIA and full terrorism coverage is provided on ALL of our policies*

Application (Application may vary depending on category and type of Social Service)

A. Applicant Information

1. **Contact Name:** _____
2. **Phone:** _____
3. **FEIN Number:** _____
4. **Broker Fee: \$** _____

B. Subsidiaries

1. **Name:** _____
Type of Operation: _____
% of ownership: _____
Date Acquired: _____
Domestic or Foreign: _____
2. **Does the applicant wish coverage to include this subsidiary? YES/NO**
If 'YES', please answer the following:
Have the services provided by this subsidiary been added as a Type of Work? YES/NO
If 'NO', you must return to the Operations screen to enter all applicable Types of Work.

C. Additional Applicant Information

1. **Annual Budget: \$** _____
If for profit, does applicant operate on a sliding scale? YES/NO
If 'YES', please explain:

2. **Please provide a breakdown of funding sources. Please indicate the percentage that is restricted versus non-restricted (Must equal 100%):**
Restricted (Funding Source, %) _____

Non-restricted (Funding Source, %) _____

3. Please describe the purpose of the organization: _____

D. Staffing and Operations

(Please attach a copy of your employment application)

	No. of Non-Employees		No. of Employees	
	Volunteers	Consultants	Full Time	Part Time
Psychiatrists				
Psychologists				
Other Physicians				
Social Workers				
Residence Managers				
Counselors				
*Medical Directors				
Ind. Licensed Practitioners				
RNs				
LPNs / LVNs				
Physical Therapists				
Speech / Occup. Therapists				
Nutritionists				
Outdoor Adventure Staff				
Teachers				
Teacher's Aides				
Home Health Staff				
Administrative / Clerical				
Maintenance / Housekeeping				
Drivers				

*Note: Do not include if counted as a psychiatrist or psychologist.

Please list other Employees (specify the position, how many are full-time, part-time, volunteers and consultants):

E. Inpatient/Outpatient Services

(Please fill out the section that corresponds to the category of social service you selected)

1. Social Service Agencies

List any age limitations on outpatient services: _____

Average age of clients: _____

Describe the types of problems treated in an outpatient setting:

If the applicant provides a recreation program, please describe activities in full detail:

If the applicant has a Big Brother / Big Sister Program,
please describe or attach screening procedures: _____

If the applicant provides group therapy sessions, answer the following:

Average size of group: _____

Average number of times the group meets per week: _____

Indicate the types of problems treated in sessions: _____

If the applicant provides a crisis hotline, please describe the training they receive
(PLEASE SEND PROTOCOLS OUTLINING THE PROCEDURES FOR HANDLING A CRISIS
HOTLINE CALL):

Indicate the types of problems treated in sessions: _____

Do you use volunteers on the hotline? YES/NO

If volunteers are used as counselors, please describe the training they receive:

Hours of operation for the hotline: _____

2. Substance Abuse Programs

Please describe all methods of detox, including the medications utilized:

3. Residential And Inpatient Care Facilities

Is the applicant a psychiatric hospital? YES/NO

Is the applicant an alternative to incarceration for youths or adults? YES/NO

Do you provide assisted living services? YES/NO

If 'YES', what is the average age of the residents? _____

Is there any age limitations of residents? YES/NO

Average age of residents: _____

Residents are (Please circle one): Male Female Both

If Both, how are they separated? _____

Average length of stay by residents? _____

How many residential locations are run by the applicant? _____

Indicate Client / Staff Ratio: _____

Describe the security measures for each residential facility: _____

How does the applicant obtain the residents utilizing the applicant's services?

How many visits are made per month by a caseworker to a resident? _____

How does the applicant handle allegations of child abuse (sexual or physical) in the residential facilities? _____

F. Representatives 1

1. Is coverage desired for non-employee consultants? YES/NO
2. Are criminal records checked prior to employment for ALL employees and non-employees? YES/NO
3. Does the applicant have a crisis management plan for dealing with staff personnel, victim, parents authorities and media if the applicant has an incident of abuse? YES/NO
4. Does the applicant discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a client/child reports someone molested/abused him or her? YES/NO
5. Is ANYONE applying for insurance under this policy aware of any state, federal, local code or professional violations, unethical misconduct, incompetence or negligence? YES/NO

If 'YES', please explain:

6. Do employee/non-employee psychiatrists, physicians, psychologist maintain individual medical malpractice coverage? YES/NO

If 'YES', what are the required limits: _____

7. Is ANYONE applying for insurance under this policy aware of any circumstances involving sex or sexual abuse/molestation with any patients, former patients or relatives thereof? YES/NO

If 'YES', please explain:

8. Does the applicant enlist the services of volunteers (a volunteer is someone who does work or provides services for the applicant, but is not an employee and includes unpaid consultants and board members)? YES/NO

If 'YES', please answer the following:

Do they go through the same screening process as employees? YES/NO

Please provide the estimated number of annual volunteer days for all locations: _____

G. Representatives 2

1. Does the applicant contract with another facility for additional beds? YES/NO

If 'YES', number of beds: _____

2. Is any percentage of the facility owned and operated by a physician? YES/NO

If 'YES', name physician(s) and percentage owned:

3. Does the applicant do any fund raising / special events? YES/NO

If 'YES', describe events and amount of receipts:

4. Is the applicant licensed by the state(s) in which it operates? YES/NO

If 'YES', term licensed:

5. Are complete records kept on all patients? YES/NO

If 'YES', where are they stored and how are they secured?

6. Does the applicant require signed release forms for the release of records to other individuals of institutions? YES/NO

H. Policy History

1. If no insurance exists, is this a new venture? YES/NO
2. Does the applicant contemplate any construction activity in the next year? YES / NO / NOT AVAILABLE
3. Does the expiring policy provide Physical/Sexual Abuse Exclusion? YES / NO / NOT AVAILABLE

If 'YES', is coverage claims made? YES/NO

If 'YES', is this a sublimit? _____

I. Claims History

1. In the past five years, has any claim or suit been made against the applicant? YES/NO
If 'YES', please fill out the table below:

Date of Claim	Claimant Name	Nature of Claim	Amount In Defense and Indemnity	Reserve Amount	Current Status

J. Coverage & Endorsements

1. Medical Services Exclusion: YES/NO
2. Outdoor Activities Exclusion: YES/NO
3. Extended Reporting Period: YES/NO

3. Add Additional Insured

Name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Insurance Interest (Funding, Landlord – If landlord provide location number): _____

4. Additional Name Insured

Name: _____

**Please Note: TRIA and full terrorism coverage is provided on ALL of our policies*

K. Physical/Sexual Abuse

1. Does the applicant's staff (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 offense? YES/NO
2. Does the applicant's state permit the applicant to do criminal background investigations? YES/NO
If 'YES', does the applicant routinely request and receive such background investigations? YES/NO
3. Does the applicant verify employment related references? YES/NO
If 'YES', by telephone, in person or both?
4. Does the applicant's organization conduct a personal interview? YES/NO
5. Does the applicant discuss at staff orientation, physical/sexual abuse and how to recognize the signs, what to do if a client/child reports someone has abused/molested him/her? YES/NO
6. Has the applicant ever had an incident which resulted in an allegation of physical/sexual abuse? YES/NO

THE FOLLOWING PORTION OF THE APPLICATION IS FOR RESIDENTIAL & INPATIENT CARE FACILITIES ONLY

L. Location Info (Part 1)

Individual Facility Questionnaire (To be completed for EACH residential facility operated by the applicant)

1. What type of problems are treated at this facility? *(Please circle one):*
Alcohol Drug Developmentally Disabled Mentally Ill Aged Other

2. Is facility ROOM AND BOARD ONLY? YES/NO
If 'NO', describe treatment methods and approach:

3. Is this a lock-up facility for residents? YES/NO
If 'YES', please describe security or provide a property inspection report:

4. Are any of the above beds, medical or non-medical, detoxification beds? YES/NO
If 'YES', how many are;

Medical: _____ Non-Medical: _____

M. Location Info (Part 2)

1. Is the applicant leasing/sub-leasing to others any portion of the locations listed? YES/NO

If 'YES', please describe:

2. Does the applicant require that his/her tenant carry liability insurance for their occupancy? YES/NO/NOT AVAILABLE

If 'YES', what are the applicant's requirements for maintenance of liability insurance by the tenant?

3. Is the applicant always added as an Additional Insured to the tenants liability policy? YES/ NO/NOT AVAILABLE

4. Are there any pools on the premises? YES/NO

If 'YES', please provide the following information:

How Many: _____

Describe: _____

Are pools used exclusively for clients? YES/NO

How is pool secured when not in use? _____

Clients Supervised? YES/NO

Are there Lifeguards? YES/NO

If 'YES', how many, and are they certified? _____

N. Location Info (Part 3)

(Please provide the following building information)

1. Year Building Was Built: _____
2. Number of Stories: _____
3. Occupied by Applicant (Stories): _____
4. Automatic Sprinklers? YES/NO
5. Heat Sensors: YES/NO
6. Smoke Detectors: YES/NO
7. Fire Escapes (#): _____
8. Plumbing Year: _____
9. Wiring Year: _____
10. Owned or Leased? _____

IMPORTANT NOTICE

IN GRANTING COVERAGE TO ANY OF THE INSURED, THE INSURER HAS RELIED UPON THE DECLARATIONS AND STATEMENTS IN THIS APPLICATION FOR COVERAGE. ALL SUCH DECLARATIONS AND STATEMENTS ARE THE BASIS OF COVERAGE AND SHALL BE CONSIDERED INCORPORATED IN AND CONSTITUTING PART OF THE POLICY SHOULD ONE BE ISSUED.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY SUBMITTED IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF. NOTHING CONTAINED HEREIN OR INCORPORATED HEREIN BY REFERENCE SHALL CONSTITUTE NOTICE OF A CLAIM OR POTENTIAL CLAIM SO AS TO TRIGGER COVERAGE UNDER ANY CONTRACT OF INSURANCE.

THIS APPLICATION DOES NOT BIND THE APPLICANT TO BUY, OR THE COMPANY TO ISSUE THE INSURANCE, BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT AND SHOULD A POLICY BE ISSUED, IT WILL BE ATTACHED TO AND MADE A PART OF THE POLICY.

THE UNDERSIGNED APPLICANT DECLARES THAT THE STATEMENTS SET FORTH IN THIS APPLICATION ARE TRUE. THE APPLICANT FURTHER DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE POLICY, SHOULD A POLICY BE ISSUED, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENT TO BIND THIS INSURANCE.

IF AND WHEN A POLICY IS ISSUED, THIS APPLICATION IS ATTACHED TO AND MADE A PART OF THE POLICY, SO IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED IN DETAIL. THE APPLICANT HEREBY ACKNOWLEDGES THAT HE/SHE IS AWARE THAT BY SIGNING BELOW WHERE INDICATED, THAT THIS SIGNED STATEMENT WILL BE ATTACHED TO THE POLICY.

NOTICE TO ARKANSAS 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 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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES."

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 INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

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 A DENIAL OF INSURANCE BENEFITS."

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

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 ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, 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 FIVE THOUSAND DOLLARS 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 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 ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY" (365:15-1-10, 36 §3613.1).

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 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 SUCH 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."

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN BELOW WHERE INDICATED. IF THIS POLICY IS ISSUED, THIS SIGNED STATEMENT WILL BE ATTACHED TO THE POLICY.

The Applicant hereby acknowledges that he/she/it is aware that the limits of insurance contained in this policy shall be reduced, and may be completely exhausted, by the costs of defense expenses which include but are not limited to attorneys fees and, in such event, the insurer shall not be liable for the costs of defense expenses or for the amount of any judgement or settlement to the extent that such exceeds the limits of insurance of this policy.

This Applicant hereby further acknowledges that he/she/it is aware that defense expenses that are incurred shall be applied against the deductible amount, if any.

Signature of Owner, Partner, Member, Principal, or Officer Authorized to Sign as Applicant

Applicant's Printed Name: _____

Title: _____

Date: _____

Producer Name: _____

License #: _____