

12. If services performed are counseling, please indicate % of total counseling:
- | | | |
|---------------------------|------------------------------|--------------------------------|
| _____ % Family planning | _____ % Drug detoxification* | _____ % S.T.D. |
| _____ % Abortion* | _____ % Drug methadone | _____ % Alcohol |
| _____ % Legal* | _____ % Family | _____ % Adoption screening* |
| _____ % Marital | _____ % Criminal* | _____ % Foster Care screening* |
| _____ % Sexual offenders* | _____ % Crisis intervention* | _____ % Domestic abuses* |
| _____ % Narcotics | _____ % Hot line* | _____ % Other (specify) |

*If any, provide specifics.

13. a. If a "For-Profit Corp.", previous 12 months receipts: \$ _____
 Anticipated receipts for policy period: \$ _____
- b. If a "Not-For-Profit", previous 12 months outpatient visits: _____
 Anticipated outpatient visits for policy period: _____
 Operating budget or funding: \$ _____
- c. Anticipated number of "Hot Line" calls for policy period: _____
- d. Is applicant engaged in, associated with or involved in any other enterprise? Yes No
 If yes, provide details _____

14. List any professional association of which applicant is a member: _____

15. Describe any professional training, licensing or certification needed for this operation: _____

16. If you are an employee, please describe your management or supervisory duties: _____

17. If you contract your services to others on an independent contractor basis, whom do you work for? _____

18. Prior insurance carrier and loss history (If none, check here):

Year	Insurance Company	Policy Number and Premium	Loss Paid & Reserved	Loss Description

19. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s)? If yes, provide details. Include description of claim, date of loss, amount(s) paid and reserved. Yes No

19. Is applicant, or any other person for whom coverage is being requested, aware of any circumstances which may result in a claim? If yes, provide details. Yes No

20. Has applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, or any policy cancelled or non-renewed in the past five (5) years? If yes, please provide details. Yes No

IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE ANSWER THE FOLLOWING QUESTIONS.

29. Please indicate the liability limits you are requesting.
 \$25,000/50,000 \$50,000/100,000 \$100,000/300,000 \$300,000/300,000
30. Please describe your hiring practices. _____

31. Do you have written guidelines regarding sexual misconduct? Yes No
32. What steps have you taken to prevent or avoid a sexual misconduct incident?
(e.g. same gender caregiver/client) _____

33. Have you or any employee, volunteer or other person working for you
ever been arrested or convicted of a crime? If yes, give details. Yes No

34. Has your facility had any incidents or claims brought against it for sexual
molestation or any other allegation of misconduct? If yes, give details. Yes No

35. Has any facility that you have been associated with in the past ever had any
incidents occur or claims brought against it while you were there? If yes, give details. Yes No

Notice to applicants: In most states any person who knowingly and with intent to defraud files an application for insurance containing any materially false information, or conceals for the purposes of misleading information concerning any fact material hereto, commits a fraudulent act, which is a crime.

Applicant's Signature: _____

Title: _____

Date: _____

Producing Agent: _____