XS BROKERS

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SOCIAL SERVICE AGENCIES APPLICATION

All questions must be fully and completely answered. If there is not enough room in the space provided, a separate page(s) may be attached. Please mark "N/A" any question that does not apply to your operation.

NOTE: In applying for coverage, applicant agrees that, in the event of covered losses, applicant will be required to be defended by the Company's appointed attorneys and that the deductible shall apply to loss including (whether or not loss payment is made) adjusting expenses, investigation costs, and legal fees. If however, applicant elects to handle a claim without in any way involving the Company's attorney, then no coverage for such claim is afforded the applicant under the Policy.

1. GENERAL INFORMATION

Name of Applicant:_____

Address: _____

City/State/Zip:_____

Phone Number:_____ Fax Number:_____

Contact Person for Inspection: _____

Name of Agent: _____

2. List all subsidiaries (attach a list if more space is required):

Name	Type of Operation	% of Ownership	Date Acquired	Domestic or Foreign

Do you wish coverage to include all subsidiaries? ☐Yes ☐No

If yes, include complete list of Directors and Officers of each subsidiary for which coverage is requested.

3. APPLICANT IS:

Non Profit: ☐ For Profit: ☐

Government: ☐ Other: ☐ (Describe:)_____

Annual Budget:_____ Years Operational:_____

If for profit, does applicant operated on a sliding scale? ☐Yes ☐No If other, please describe in detail._____

_____

Please provide a breakdown of funding sources. Please indicate the percentage that is restricted versus non-restricted (Must equal 100%)_____

_____

Please describe the purpose of the organization._____

_____

Are you licensed by state or local authorities: ☐Yes ☐No

If yes, name the authority:_____

4. STAFFING AND OPERATIONS: PLEASE ATTACH A COPY OF YOUR EMPLOYMENT APPLICATION

Profession	# of EMPLOYEES Full Time	Part Time	# of NON EMPLOYEES Volunteers	Consultants
Psychiatrists(M.D.s)*	_____	_____	_____	_____
Other Physicians(M.D.s)*	_____	_____	_____	_____
Psychologists(M.D.s)*	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Others (Specify Position)	_____	_____	_____	_____

***Please List Names on a separate sheet**

5. OUTPATIENT SERVICES:

PROVIDE # OF ANNUAL CLIENT VISITS FOR EACH DESCRIPTION CHECKED:

☐ Hospice (Outpatient) ____
☐ Mental Health Day Care ____
☐ Outpatient Counseling ____
☐ Sheltered Work Shop ____
☐ Mental Retardation (including ARC) and/Cerebral Palsy Centers: ____
☐ Recreation Programs ____
☐ Crisis Hotline ____ # of calls annually
☐ Crisis Center ____
☐ Day School ____
☐ Mental Health Day School ____
☐ Referral Agencies ____
☐ Big Brothers/Sisters (# of children) ____
☐ Training: please describe and include # clients:
_____
_____
☐ OTHER SERVICES -please describe and include # of client VISITS:
_____
_____

a. Are there any age limitations on the above captioned services:_____

b. Average age of clients:_____

c. Describe the types of problems treated in an outpatient setting:_____

_____

d. If the applicant provides a **recreation program**, please describe activities in full detail:_____

_____

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

_____

f. If the applicant provides **group therapy** sessions, answer the following:

1. Average size of the group:_____
2. Average number of times the group meets per week:_____
3. Indicate the types of problems treated in sessions:_____

g. If the applicant provides a **crisis hotline**, please answer the following:

1. What types of problems are treated by the hotline?_____
2. Do you use volunteers on the hotline? ☐ Yes ☐No
3. If volunteers are used as counselors, please describe the training they receive:_____
4. Hours of operation for the hotline:_____

PLEASE ATTACH PROTOCOLS OUTLINING THE PROCEDURES FOR HANDLING A CRISIS HOTLINE CALL.

6. ADOPTION & FOSTER CARE:

☐ Adoption Placements: ☐ Foster Care Placements:

_____# of Child/Adolescent Placements (Annual)
_____# Adult Placements
_____# Aged/Elderly Placements

_____# of Child/Adolescent Placements (Annual)
_____# Adult Placements
_____# Aged/Elderly Placements

Foster Care:

a. What are the ages of children placed in foster homes?_____

b. How many foster homes do you utilize?_____

c. Are they licensed by applicable state and /or local authorities? ☐Yes ☐No

If not, who licenses the foster homes?_____

d. Describe the process used to obtain foster homes:_____

_____

_____

e. How often are children moved from one foster home to another?_____

f. How often does the applicant's employees visit the children in the foster homes?_____

g. Who compensates the foster parents?_____

h. How does the applicant handle allegations of child abuse (sexual or physical) in the foster homes?_____

Adoption:

i. What are the ages of the children placed?_____

j. Outline the adoption procedures:_____

_____

_____

k. Does the applicant have legal custody of the child? ☐Yes ☐No

l. Is a guardian appointed to ensure the child's welfare?_____

m. If you provide **INTERNATIONAL PLACEMENTS**, please answer the following:

1. What percentage of your services are **FOREIGN ADOPTIONS**?_____
2. Please list all of the countries you work with and the respective number of adoptions placed in the last year:

Country	**Number of Adoptions**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please attach a separate page if necessary

3. Do you accompany the parent to and from the country with the adoptive child? ☐Yes ☐No

If no, please explain:_____

4. How do you verify the health of the foreign adoptive child?_____

_____

5. How do you select and screen physicians in the foreign country of the adoptive child?_____

_____

6. Are you a member of the Joint Council on International Children's Services or other similar agency (please list):____

_____

7. Do you provide counseling services on passport requirements for the adoptive child, cultural issues, medical and legal issues, financial requirements, waiting periods and post-adoptive counseling? ☐Yes ☐No
Please explain:_____

_____

8. Please describe your procedures for verifying an adoptive child's mental and physical health (attach a separate page if necessary or written procedures):_____

7. ELDERLY/AGED SERVICES:

☐ Meals on Wheels: ____ # of meals annually
☐ Agency for the aged/seniors ____# annual client contacts
a. Please describe the nature of the activities at the agency or senior center:_____

8. SUBSTANCE ABUSE PROGRAMS:

PLEASE INDICATE THE NUMBER OF ANNUAL CLIENT CONTACTS

☐ DUI Classes	____	☐ Non-medical Detox (Secondary Stage)	____
☐ Methadone Maintenance	____	☐ Alcohol/Drug Counseling (Outpatient)	____
☐ Inpatient Detox # of Beds	____		

a. Please describe the average age of clients utilizing these services:_____

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

9. RESIDENTIAL PROGRAMS:

PLEASE INDICATE THE NUMBER OF BEDS

☐ Contracted Beds	____	☐ Group Home (3+ Months)	____
☐ Group & Residential Home	____	☐ Halfway House	____
☐ Home for the Battered	____	☐ Inpatient Mental Health	____
☐ Supervised Living	____	☐ Residential Treatment MH/MR	____
☐ Hospice	____	☐ Psychiatric Hospital	____

☐ OTHER SERVICES -please describe and include # of client VISITS:

a. Are you a psychiatric hospital? ☐Yes ☐No
b. Are you an alternative to incarceration for youths or adults? ☐Yes ☐No
c. Do you provide assisted living services? ☐Yes ☐No
If yes, what is the average age of the residents:_____
d. Is there any age limitations of residents?_____
e. Average age of residents:_____
f. Residents are: ☐Male ☐Female ☐Both
If both, how are they separated:_____
g. Average length of stay by residents:_____
h. How many residential locations are run by the applicant?_____
i. Indicate Client/Staff Ratio:_____
j. Describe the security measures for each residential facility:_____
k. How does the applicant obtain the residents utilizing the applicant's services?_____
l. How many visits are made per month by a caseworker to a resident?_____
m. How does the applicant handle allegations of child abuse (sexual or physical) in the residential facilities?_____

RESIDENTIAL OPERATIONS: PLEASE COMPLETE SEPARATE RESIDENTIAL QUESTIONAIRE FOR EACH LOCATION

10. REPRESENTATIONS

A. Please provide a claims history for ALL contracted or employed physicians.

B. Do employee/non-employee psychiatrists, physicians, psychologist maintain individual medical malpractice coverage?
☐Yes ☐No Required Limits:_____

C. Are criminal records checked prior to employment for **ALL** employees and non-employees? ☐ Yes ☐No

D. 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/abused him or her? ☐Yes ☐No

E. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? ☐Yes ☐No

F. Do you have a crisis management plan for dealing with staff personnel, victim, parents authorities and media if you have an incident of abuse? ☐Yes ☐No

G. Is coverage desired for non-employee consultants? ☐Yes ☐No
IF COVERAGE IS DESIRED, PLEASE LIST NAMES AND TITLES ON A SEPARATE SHEET.

H. Are any medications prescribed by the Applicant? ☐Yes ☐No
IF YES, ATTACH A LIST ADVISING WHAT MEDICATIONS ARE PRESCRIBED, BY WHOM, FOR WHAT PURPOSE AND HOW THE MEDICATIONS ARE SECURED

I. 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 DESCRIBE ON A SEPARATE SHEET.

J. 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 DESCRIBE ON A SEPARATE SHEET.

K. Does ANYONE applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? ☐Yes ☐No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

L. 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:
   a. Do they go through the same screening process as employees? ☐Yes ☐No
   b. Please provide the estimated number of annual volunteer days for all locations: _____

M. Do you contract with another facility for additional beds? ☐Yes ☐No
If yes, number of beds:_____
PLEASE PROVIDE A COPY OF THE CONTRACT

N. Is any percentage of the facility owned and operated by a physician? ☐Yes ☐No
If yes, name physician(s) and percentage owned:_____

O. Does the applicant do any fund raising/special events? ☐Yes ☐No
Describe events and amount of receipts:_____

P. Is the applicant licensed by the state(s) in which it operates? ☐Yes ☐No
Term Licensed:_____
Has license ever been suspended or revoked?_____
PLEASE ATTACH COPY OF ALL LICENSES HELD AND ATTACH LATEST HEALTH DEPARTMENT INSPECTION.

Q. Are Complete records kept on all patients? ☐ Yes ☐No
Where are they stored and how are they secures?_____

R. Does the applicant require signed release forms for the release of records to other individuals of institutions?
☐ Yes ☐No

11. SUPPLEMENTAL INFORMATION
Please list all additional insured and their addresses, check coverage required and their insurable interest.

A. Name: _____ Insurance Interest (funding, landlord-if
Address_____ landlord provide location number_____

General Liability☐ Professional Liability☐

B. Name: _____ Insurance Interest (funding, landlord-if
Address_____ landlord provide location number_____

General Liability☐ Professional Liability☐

C. Name: _____ Insurance Interest (funding, landlord-if
Address_____ landlord provide location number_____

General Liability☐ Professional Liability☐

RECORD OF EXISTING INSURANCE

COVERAGE	COMPANY	LIMITS	PREMIUM	EFF. DATE	RETRO DATE
PROFESSIONAL LIABILITY					
GENERAL LIABILITY					
EXCESS AND/OR UMBRELLA					

12. If no insurance exists, is this a new venture? ☐ Yes ☐No
If no, please explain: _____

Is expiring professional liability coverage on a claims made policy? ☐Yes ☐No Retroactive Date: _____
If yes, do you desire prior acts coverage? ☐Yes ☐No

PLEASE PROVIDE PROOF OF UNINTERRUPTED CLAIMS MADE COVERAGE.

13. Does this policy provide Physical/Sexual Abuse Exclusion? ☐Yes ☐No
If yes, is this a sublimit? ☐Yes ☐No Limit: _____
Is coverage claims made? ☐Yes ☐No Retro Date: _____

14. CLAIMS HISTORY
Has the applicant had ANY Professional Liability or General Liability claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past 5 years? ☐Yes ☐No
IF YES, PLEASE DESCRIBE IN DETAIL-DATE CLAIM REPORTED, DATE OF LOSS, ALLEGATIONS, AMOUNT RESERVED/PAID, CURRENT STATUS (OPEN OR CLOSED).

15. CONTRACTORS LIABILITY
Does the applicant contemplate any construction activity in the next year? ☐Yes ☐No If yes, describe and estimate contracts costs:_____

16. PRODUCTS/COMPLETED OPERATIONS
Does the applicant sell goods or services to members of the public (other than to clients)? ☐Yes ☐No

If yes, describe products, and/or services and estimate annual receipts for each:
Products:_____ Annual Receipts:_____
Services:_____ Annual Receipts:_____

17. EMPLOYER'S AUTOMOBILE NON-OWNERSHIP LIABILITY
Is non-owned auto coverage desired? ☐Yes ☐No
If yes, do you desire coverage for volunteers and employees? ☐Yes ☐No
Do you check driving records of all drivers, including volunteers? ☐Yes ☐No
What is the underlying insurance limit carried by the owner?_____

What are the vehicles used for?_____

Number of vehicles:_____

The undersigned authorized representative of the applicant declares that (1) the statements set forth herein are true, and (2) if the information supplied on this application changes between the date of this application and the effective date of the insurance, the undersigned will immediately notify LEXINGTON INSURANCE COMPANY of such changes, and LEXINGTON INSURANCE COMPANY may withdraw or modify any outstanding quotations and/or agreement to bind the insurance. Furthermore, signing this form does not bind the applicant or the company to complete this insurance.

NOTICE: COVERAGE IS WRITTEN WITH A NON-ADMITTED CARRIER, PRODUCER WARRANTS THAT ALL INSURANCE REQUIREMENTS OF APPLICANTS HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH, INCLUDING MAKING THE SURPLUS LINES FILING AND SUBMITTING SURPLUS LINES FEES AND TAXES, WHERE APPLICABLE.

NOTICE TO ARKANSAS APPLICATIONS: "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 KNOWLINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR 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 AGENCIES."

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLIAM 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 MATERIALTHERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME."

NOTICE TO 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."

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 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."

PLEASE REMEMBER TO ATTACH ALL SEPARATE STATEMENTS, LOSS RUNS, COPY OF LICENSE HELD, HEALTH DEPARTMENT INSPECTIONS, INCLUDING THE FOLLOWING:

- EMPLOYMENT APPLICATION
- FIVE YEAR LOSS RUN
- LIST OF DIRECTORS AND OFFICERS
- CRISIS HOTLINE PROTOCOLS

Date:_____ Signature:_____

(Applicant/Owner/President)

Title:_____

Please return to:

XS Brokers
Ten Granite Street
Floor 2
Quincy, MA 02169
Telephone: 617-471-7171
Fax: 617-471-7180

SOCIAL SERVICE AGENCY APPLICATION

INDIVIDUAL FACILITY QUESTIONNAIRE

To be complete for EACH residential Facility operated by applicant

LOCATION NO._____ Number of Beds_____

1. Name of Facility:_____

   Address:_____

2.

A. YEAR OF CONSTRUCTION	
B. NUMBER OF STORIES	
C. OCCUPIED BY APPLICANT (Stories)	
D. PROTECTIVE DEVICES Automatic Sprinklers Heat Sensors Smoke Detectors	 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
E. FIRE ESCAPES	#_____
F. Swimming Pool	☐Yes ☐No
G. Year of Updates in Construction *Plumbing *Wiring	Year:_____ ☐Yes ☐No ☐Yes ☐No
H. Owned or Leased	

3. This location operates as:_____
   Average length of stay:_____

4. What types of problems are treated at this facility?

   ☐Alcohol ☐Drug ☐Mental Retardation ☐Mentally Ill ☐Aged
   ☐Other:_____
   Please describe on a separate sheet if necessary

5. Is facility ROOM AND BOARD ONLY? ☐Yes ☐No
   If no, describe treatment methods and approach:

   _____

   _____

6. Is this a lock-up facility for residents? ☐Yes ☐No
   If yes, please describe security or provide a property inspection report._____

   _____

7. Are any of the above beds, medical or non-medical detoxification beds? ☐Yes ☐No
   If yes, How many? Medical_____ Non-Medical_____

8. **OPERATIONAL AND PREMISES INFORMATION**

A. Are you leasing/sub-leasing to others any portion of the locations listed? ☐Yes ☐No
If yes, please describe occupancy.

_____

B. Do you require that your tenant carry liability insurance for their occupancy? ☐Yes ☐No

What are your requirements for maintenance of liability insurance by the tenant?

_____

C. Are you always added as an Additional Insured to the tenants liability policy? ☐Yes ☐No

D. Are there any pools on the premises? ☐Yes ☐No
How Many?_____

Describe:_____

Are pools used exclusively for clients?_____

How is pool secured when not in use?_____

Are clients supervised? ☐Yes ☐No

Are there Lifeguards? ☐Yes ☐No
How Many? _____

Are they certified? ☐Yes ☐No

E. Do you provide medical services? ☐Yes ☐No

F. Is transportation provided to clients? ☐Yes ☐No