The Hanover Insurance Group™

HUMAN SERVICES ADVANTAGE
Developmental Disabilities
Underwritten by THE HANOVER INSURANCE COMPANY

New Business Questionnaire

INSTRUCTIONS

Whenever used in this Questionnaire, the term "Applicant" shall mean the Named Insured and all subsidiaries or other organizations applying for coverage, unless otherwise stated.

The Applicant must complete this Questionnaire in accordance with the specific coverages requested, along with any additional underwriting information or attachments as indicated.

PLEASE ATTACH THE FOLLOWING WITH SUBMISSION:

- Completed ACORD application(s)
- Updated statements of value
- Updated schedule of vehicles/drivers list

I. GENERAL INFORMATION

Applicant Name: _____ Website: _____

Contact Person for Inspection: _____ FEIN: _____

Email: _____

1. Type of entity: ☐ For-Profit ☐ Non-Profit
2. Has your organization received any investments from private equity funds? ☐ Yes ☐ No
3. Number of years in operation: _____ Years under present management: _____
4. Name of executive director/manager: _____

   Number of years in this field: _____ Number of years at this facility: _____
5. Do you operate any licensed facilities? ☐ Yes ☐ No
6. Have any of your licenses ever been under investigations, suspended, revoked, voluntarily surrendered, or placed under conditional or probationary status? ☐ Yes ☐ No

   If yes, please provide details and explanation: _____

   _____
7. Have any past allegations of abuse or other serious violations been made by any licensing agencies? ☐ Yes ☐ No

   If yes, please explain and provide a copy of the investigative report, if applicable: _____

   _____
8. Annual operating budget: $ _____ Annual payroll: $_____
9. Have you ever discontinued any programs? ☐ Yes ☐ No

   If yes, please provide details and explanation, including dates: _____

   _____
10. Are you currently accredited? ☐ JCAHO ☐ CARF ☐ COA ☐ Other:_____
11. Prior Carrier Information:

	NO PRIOR COVERAGE	COMPANY	LIMITS	COVERAGE	RETROACTIVE DATE	ANNUAL PREMIUM

Professional Liability	☐	_____	$_____	☐ Occurrence ☐ Claims-Made	_____	$_____
General Liability	☐	_____	$_____	☐ Occurrence ☐ Claims-Made	_____	$_____
Abuse & Molestation	☐	_____	$_____	☐ Occurrence ☐ Claims-Made	_____	$_____

Professional Liability Deductibles – Optional. (If no option selected, no deductible will apply.)

☐ $1,000	☐ $2,500	☐ $5,000	☐ $10,000	☐ $25,000

II. MANAGEMENT PRACTICES

1. Is the staff required to report to the administrator all incidents that may result in a claim? ☐ Yes ☐ No
2. Are written records of all incidences kept by the administrator & reviewed? ☐ Yes ☐ No
3. Do you have a formal written safety program in place? ☐ Yes ☐ No
4. Do you have a plan in place for medical emergencies? ☐ Yes ☐ No
5. If you contract for services, do you require the contractors to sign a hold harmless or indemnification agreement? ☐ Yes ☐ No

   If yes, attach a copy of the standard agreement.
6. If you contract for services, are certificates of insurance required and kept in file for those contractors? ☐ Yes ☐ No

   If yes, what are the minimum limits of liability? $_____
7. What type of method do you use for de-escalation? _____
8. How often is the staff recertified? _____
9. Are physical interventions used? ☐ Yes ☐ No

   If so, what method(s) do you use? _____
10. Is training conducted: ☐ At Hire ☐ Annually After Hire
11. How many interventions were executed over the last 12 months? _____
12. What security measures are in place for the protection of your clients/residents? Check all that apply.

    ☐ Video Cameras ☐ Electronic Locks ☐ Door Alarms ☐ Wander-Guard

    ☐ Other: _____
13. Do you use security personnel at any of your locations? ☐ Yes ☐ No

    If yes, are they: ☐ Contracted? ☐ Employed? # Full Time: _____ # Part Time: _____
14. If security personnel are contracted, do you require the security firm to carry its own liability insurance? ☐ Yes ☐ No

    If yes, what limits do they carry? $_____
15. Please list all locations where security personnel are used: _____

16. If contracted, please provide the name of the security firm or police department used: _____

17. Do you obtain certificates of insurance granting you additional insured status from your subcontractors? ☐ Yes ☐ No

    If yes, attach a copy.

18. Are security personnel armed? ☐ Yes ☐ No

19. Describe the minimum requirements and training for security personnel: _____

20. Please indicate whether sign in/out procedures are in place for:

    ☐ Staff ☐ Clients/Residents ☐ Visitors/Public

21. Do you have a formal incident review committee? ☐ Yes ☐ No

22. Do you have written client intake and discharge protocol? ☐ Yes ☐ No

23. Are you able to decline prospective clients if you are not able to provide the level of care needed? ☐ Yes ☐ No

24. Are you able to discharge clients from your care if necessary? ☐ Yes ☐ No

25. For what reasons would you need to decline or discharge a client from your care? _____

26. Do you ever co-sign lease agreements for your clients if they do not qualify for housing on their own? ☐ Yes ☐ No

III. PROFESSIONAL LIABILITY

1. With respect to your hiring practices:

   a. Are formal written procedures in place for staff hiring? ☐ Yes ☐ No

   b. Do you require your staff to complete an employment application? ☐ Yes ☐ No

   c. Do you conduct a personal interview for each prospective staff member? ☐ Yes ☐ No

   d. Do you verify employment related references? ☐ Yes ☐ No

   e. Do you verify licenses and other credentials? ☐ Yes ☐ No

2. Indicate the number of staff: Total employees: _____ Total volunteers: _____

POSITION	EMPLOYEES		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Child Case Worker								
Counselor (other)								
Home HealthAide								
Nurse Practitioner								
Nurse – LPN								
Nurse – RN								

Nutritionist	_____	_____	_____	_____	_____	_____	_____	_____
Physician	_____	_____	_____	_____	_____	_____	_____	_____
Physician Assistant	_____	_____	_____	_____	_____	_____	_____	_____
Psychiatrist	_____	_____	_____	_____	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____	_____	_____	_____	_____
Resident Manager	_____	_____	_____	_____	_____	_____	_____	_____
Social Worker – Bachelors (BSW)	_____	_____	_____	_____	_____	_____	_____	_____
Social Worker – Masters (MSW)	_____	_____	_____	_____	_____	_____	_____	_____
Teacher/Tutor/Aide	_____	_____	_____	_____	_____	_____	_____	_____
Therapist – Physical/Occupational	_____	_____	_____	_____	_____	_____	_____	_____
Therapist – Speech/Hearing	_____	_____	_____	_____	_____	_____	_____	_____
Other Positions (specify)	_____	_____	_____	_____	_____	_____	_____	_____
Other Positions (specify)	_____	_____	_____	_____	_____	_____	_____	_____

3. Do you perform any consulting work? ☐ Yes ☐ No

   If yes, please explain: _____

4. Do you have a medical clinic? ☐ Yes ☐ No

   If yes, the facilities are for:
   - ☐ Staff
   - ☐ Clients/Residents
   - ☐ General Public

5. Do you provide more than immediate care/first aid? ☐ Yes ☐ No

   If yes, please explain: _____

6. Are medications dispensed? ☐ Yes ☐ No

   If yes, answer the following questions:

   a. Where are the medications stored? _____

   b. Who has the authority to dispense medications? _____

   c. Can over-the-counter medicines be dispensed without written permission from a doctor? ☐ Yes ☐ No

   d. Are written records kept as to the time, type of medication, amount of dosage and who dispensed the medications? ☐ Yes ☐ No

7. What is the turnover percentage for professional staff? _____ %

8. If you employ, contract, or accept volunteer Nurse Practitioners:

   a. Do your Nurses Practitioners prescribe medication? ☐ Yes ☐ No

      If so, how many Nurse Practitioners prescribe medication? _____

   b. Do your Nurse Practitioners provide services to individuals other than your clients? ☐ Yes ☐ No

      If yes, please explain: _____

9. Please complete the table below for any Psychiatrists, MDs, Nurse Practitioners, Dentists, or Optometrists (employed or contracted):

NAME	Dr. _____	Dr. _____	Dr. _____
Specialty	_____	_____	_____
Board Certified or Eligible	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Years in Practice	_____	_____	_____
License Number	_____	_____	_____
Hours per week for Insured	_____	_____	_____
Employed or Contracted	☐ Employed ☐ Contracted	☐ Employed ☐ Contracted	☐ Employed ☐ Contracted
Carries own Malpractice Insurance	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, does coverage include Contingent Coverage for this agency?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any claims in past five (5) years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

***Provide Certificate of Medical Malpractice for each Psychiatrist, Physician and Nurse Practitioner, Dentist, or Optometrist.

10. If the insured has had any claims in past five (5) years, please explain: _____

_____

IV. ABUSE COVERAGE

1. Does your State allow your employment application to include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses? ☐ Yes ☐ No

   If allowed, do you ask the question on your employment application(s)? ☐ Yes ☐ No

2. Please check all elements below that are utilized in your criminal background screening?

	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Current County of Residence	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
All Additional Counties of Residence from the Last Seven (7) Years	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
State Level Criminal Background Check	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Multi-State Criminal Database	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
FBI Fingerprinting	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
National Sex Offender Registry	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. Please check details below on if and when criminal background checks are repeated after hiring:

   Employees ☐ Yes ☐ No If yes, how often: _____
   Volunteers ☐ Yes ☐ No If yes, how often: _____
   Contractors ☐ Yes ☐ No If yes, how often: _____

4. Do you have written procedures for dealing with allegations of physical and sexual abuse (separate from a Sexual Harassment Policy)? ☐ Yes ☐ No

   If yes, attach a copy of the procedures.

5. Are you aware of any abuse or molestation claims, allegations, or incidences made against your organization, or against anyone working on your behalf? ☐ Yes ☐ No

   If yes, was the claim filed? ☐ Yes ☐ No The claim is: ☐ Open ☐ Closed

6. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients both on and off-premises? ☐ Yes ☐ No

7. Are procedures in place to avoid one-on-one situations so that more than one employee/ volunteer is present at all times when a client is in your care? ☐ Yes ☐ No

   Please explain any situations where that is not possible: _____

   _____

8. Is there documented formal staff training on client/sexual abuse, including how to recognize the signs and how to report a known or suspected incident? ☐ Yes ☐ No

   If so, how frequently is the training repeated? _____

9. What is the total number of unduplicated clients served annually? _____

10. Indicate the annual number of clients served in each age range for all programs/services:

    0-8 years: _____ 9-18 years: _____ Over 18 years: _____

11. Do you have any mentoring programs that match clients with mentors? ☐ Yes ☐ No

    If yes, are all interactions supervised by your staff with strict rules against outside contact? ☐ Yes ☐ No

12. If you allow interactions outside of your organization's programs (i.e. babysitting, private tutoring, coaching, clients visiting staff at home, meeting for coffee, personal travel, errands, etc.), what are your policies and any restrictions/mechanisms to manage boundaries?

    _____

    _____

V. AUTOMOBILE

☐ Check here if no owned autos

1. Are all vehicles that are used by the business listed on the ACORD application and titled to the applicant? ☐ Yes ☐ No

   If no, please explain: _____

2. DOT Number: _____

3. What are the average annual miles each vehicle is driven?

   Cars: _____mi 1-8 passenger vans: _____mi

   9-20 passenger vans: _____mi 20+ passenger buses: _____mi

4. Do you have a written fleet safety and vehicle maintenance program? ☐ Yes ☐ No

5. How many vehicles are equipped with a:

   a. Wheelchair lift? _____

   b. Wheelchair ramp? _____

6. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passengers? ☐ Yes ☐ No

7. Are all ADA requirements met for transport of clients? ☐ Yes ☐ No

8. Do you conduct annual competency-based performance reviews on drivers of the vehicles equipped with wheelchair lifts that include:

   a. Correct operation of the lift or ramp system? ☐ Yes ☐ No

   b. Properly securing the wheelchair and patient? ☐ Yes ☐ No

   c. Safely unloading the wheelchair and patient? ☐ Yes ☐ No

d. Use of company communications system? ☐ Yes ☐ No

9. Do you require both a vehicle operator and a passenger monitor when transporting multiple clients? ☐ Yes ☐ No

10. Do you transport clients for other human services agencies? ☐ Yes ☐ No

11. Do you offer "dial-a-ride" or other similar public transportation services? ☐ Yes ☐ No

If yes to Question 10. and/or Question 11.,

a. Provide an explanation: _____

b. What are the annual revenues from transporting for "dial-a-ride" or for providing transport to clients for other human services agencies? $_____

12. Do you lend your vehicles to other agencies or organizations? ☐ Yes ☐ No

If yes, please explain: _____

13. Is there a written accident investigation program in place? ☐ Yes ☐ No

14. Do you obtain Motor Vehicle Reports (MVRs) upon hire? ☐ Yes ☐ No

If yes, how frequently are MVRs run after hire?

_____

15. Are clients permitted to drive insured vehicles? ☐ Yes ☐ No

If yes, please explain: _____

16. Do you allow personal use of your owned vehicles? ☐ Yes ☐ No

If so, by whom and for what reason(s)? _____

17. Is training provided for new employees/volunteers prior to their transporting clients? ☐ Yes ☐ No

18. Do you have written rules governing the use of cell phones while driving? ☐ Yes ☐ No

19. Do you have any 15 passenger vans? ☐ Yes ☐ No

If so, how many? _____

20. Are your 15 passenger vans equipped with Electronic Stability Control (ESC)? ☐ Yes ☐ No

21. Are drivers under the age of 23 or volunteers allowed to drive 15 passenger vans? ☐ Yes ☐ No

22. Is there a formalized 15 passenger van driver training program in place for all drivers that requires:

a. Passenger seating order (i.e., front seats first)? ☐ Yes ☐ No

b. Cargo storage (i.e., stored low to the floor, never on top of van, never tow trailers)? ☐ Yes ☐ No

c. All trips be limited to 10 passengers or less? ☐ Yes ☐ No

d. Daily documented tire pressure and condition inspections? ☐ Yes ☐ No

23. Is a pre-trip and post-trip inspection log kept? ☐ Yes ☐ No

24. Are vehicles equipped with telematics? ☐ Yes ☐ No

If yes, are the devices provided to your current insurance carrier? ☐ Yes ☐ No

25. Do you have dash cams or video surveillance in your vehicles? ☐ Yes ☐ No

VI. HIRED AND NON-OWNED AUTOMOBILE

1. Are any vehicles leased or hired? ☐ Yes ☐ No

   If yes, describe what types, what uses, and how often: _____

   _____

2. Do you hire from a transportation company? ☐ Yes ☐ No

   If yes, with drivers? ☐ Yes ☐ No

3. What is the total number of hired vehicles? _____

4. What is the annual cost of hire? $_____

5. How many drive personal vehicles for business use regularly? F/T _____ P/T _____ Volunteers _____

6. How many drive personal vehicles for business use occasionally? F/T _____ P/T _____ Volunteers _____

7. How many drive personal vehicles to transport clients? F/T _____ P/T _____ Volunteers _____

8. What is the total milage reimbursement amount of the last twelve (12) months? $_____

9. Do you require your employees/volunteers that use their own autos to carry and provide evidence of personal auto insurance? ☐ Yes ☐ No

10. Is proof of personal auto insurance required on a renewal basis? ☐ Yes ☐ No

    If so, do you require minimum limits of $100K/$300K? ☐ Yes ☐ No

VII. DONATED VEHICLES OR OTHER MOTORIZED CRAFT

1. Do you accept donations of: ☐ Vehicles ☐ Boats ☐ Other: _____
2. How many are donated annually? Vehicles _____ Boats _____ Other: _____
3. How many are sold annually? Vehicles _____ Boats _____ Other: _____
4. Are they sold “as-is” with no warranty/guarantee? ☐ Yes ☐ No
5. Are any used for the operations of the organization? ☐ Yes ☐ No

VIII. RESIDENTIAL SERVICES ☐ N/A

1. Please complete the following table for all residential locations. If additional space is needed, please attach separately.

LOCATION	TYPE OF FACILITY	NUMBER OF BEDS	NUMBER OF DAY STAFF	NUMBER OF NIGHT STAFF	LEVEL OF CLIENT DISABILITY	
					# MILD/ MODERATE	# SEVERE/ PROFOUND

2. Are all residential facilities licensed? ☐ Yes ☐ No

3. Have any of your facilities ever had their license suspended/revoked? ☐ Yes ☐ No

   If yes, please explain: _____

4. What is the annual number of residential clients by age? Under 18 _____ 18-65 _____ Over 65: _____

5. Are males segregated from females (other than family members)? ☐ Yes ☐ No

   If yes, describe how they are separated: _____

6. Does a physician screen clients prior to admission? ☐ Yes ☐ No

7. Is 24-hour "awake" staff supervision provided? ☐ Yes ☐ No

8. How often are rooms inspected? _____

9. Who performs the inspections? _____

10. Do you have written inspection procedures for staff to follow? ☐ Yes ☐ No

11. Do you have a checklist to follow and retain documentation of inspection? ☐ Yes ☐ No

12. How often are bed checks done? _____

13. Are bed checks done: ☐ At random? ☐ On a schedule? ☐ N/A

14. Are residents' rooms ever locked from the outside? ☐ Yes ☐ No

15. Is there a formal elopement/run away policy? ☐ Yes ☐ No

16. Are residents required to notify the facility when leaving and returning? ☐ Yes ☐ No

17. How many residents have individual care plans that include monitoring food intake due to potential choking hazards? _____

18. How many residents are:

    a. Non-ambulatory? _____

    b. Bed-ridden? _____

    c. Non-communicative? _____

19. How many residents have acquired/traumatic brain injuries or a history of seizures? _____

20. How many residents have dementia/Alzheimer's? _____

    a. Are clients with dementia all grouped in the same facility or facilities? ☐ Yes ☐ No

    b. Are these facilities licensed for memory care? ☐ Yes ☐ No

    Please describe the controls in place to prevent elopement of these clients: _____

    _____

21. How many residents display self-injurious behavior? _____

    Please describe controls in place to monitor these clients: _____

    _____

22. How many residents display inappropriate sexual behavior? _____

    Please describes controls in place to monitor the interactions of these clients with others: _____

    _____

23. Do any residents use ventilators? ☐ Yes ☐ No

If so, how many? _____

24. Do any residents require the use of feeding tubes? ☐ Yes ☐ No

    If so, how many? _____

25. Are any residents considered medically fragile? ☐ Yes ☐ No

    If so, how many? _____

IX. DAY SERVICES

☐ N/A

1. What is the annual number of clients in day programs? _____
2. What is the average daily attendance? _____
3. What is your staff to client ratio? _____
4. Are any medical services provided? ☐ Yes ☐ No

   If yes, please describe: _____

5. How many clients in your day programs have individual care plans that include monitoring food intake due to potential choking hazards? _____
6. How many clients in your day programs have acquired/traumatic brain injuries or a history of seizures? _____
7. How many clients in your day programs have dementia/Alzheimer's? _____

   Please describe the controls in place to prevent elopement of these clients: _____

   _____

X. IN-HOME SERVICES

☐ N/A

1. What is the annual number of clients receiving in-home services by age:
   Under 18 _____ 18-65 _____ Over 65: _____
2. How many provide in-home services? Employees _____ Volunteers _____
3. Please check services offered: (Check all that apply)

   ☐ Dressing ☐ Bathing ☐ Eating ☐ Housework
   ☐ Restroom Aid ☐ Repositioning ☐ Blood Testing ☐ Changing Catheters
   ☐ Medication Management ☐ Driving to/from appointments
   ☐ Nursing Care ☐ GT Care

4. How many clients have individual care plans that include monitoring food intake due to potential choking hazards? _____
5. How many clients are:
   a. Non-ambulatory? _____
   b. Bed-ridden? _____
   c. Non-communicative? _____
6. How many clients have acquired/traumatic brain injuries or a history of seizures? _____
7. How many clients have dementia/Alzheimer's? _____

   Please describe controls in place to prevent elopement of these clients: _____

8. How many clients display self-injurious behavior? _____
   Please describe controls in place to monitor these clients: _____
   _____
9. How many clients display inappropriate sexual behavior? _____
   Please describe controls in place to monitor their interactions with staff: _____
   _____
10. Do any clients require the use of ventilators? ☐ Yes ☐ No
    If so, how many? _____
11. Do any clients require the use of feeding tubes? ☐ Yes ☐ No
    If so, how many? _____
12. Are any clients considered medically fragile? ☐ Yes ☐ No
    If so, how many? _____

XI. ADULT FOSTER CARE/HOST HOMES/SHARED LIVING ☐ N/A

1. What is the total number of placements made over the last twelve (12) months? _____
2. What is the expected number of placements over the next twelve (12) months? _____
3. What is the total number of clients placed in community at this time? _____
4. How many caseworkers/case managers handle placed clients? _____
5. How often does someone from your organization visit homes? _____
6. Are in-home visits: ☐ Scheduled ☐ Unscheduled
7. Do home visits include a consultation with the client? ☐ Yes ☐ No
   If yes, is the consultation done: ☐ Alone with Client ☐ Group ☐ Other: _____

XII. THERAPEUTIC HORSEBACK RIDING ☐ N/A

1. What is the annual number of clients in this program? _____
2. Are liability waivers signed by all participants and/or parents/guardians? ☐ Yes ☐ No
3. Do you follow North American Riding for the Handicapped Association standards? ☐ Yes ☐ No
4. Are all instructors licensed/certified? ☐ Yes ☐ No
5. Are safety helmets mandatory? ☐ Yes ☐ No
6. What is the ratio of riders to instructors? _____:_____
7. What is the minimum rider age? _____
8. Is all riding done for solely therapeutic purposes? ☐ Yes ☐ No
   If no, please explain other riding activities: _____
   _____

XIII. VOCATIONAL PROGRAMS/SHELTERED WORKSHOPS

☐ N/A

1. Do you place clients in outside employment? ☐ Yes ☐ No
   a. If yes, what is the frequency of follow up? _____
   b. If yes, do you provide transportation for these clients to their outside employment? ☐ Yes ☐ No
2. Do you operate a sheltered workshop? ☐ Yes ☐ No
   a. What is the average number of clients per day? _____
   b. What is the average number of supervisors per day? _____
   c. Do you provide transportation to/from the workshop? ☐ Yes ☐ No
   d. Are all participants covered by your Worker's Compensation Insurance? ☐ Yes ☐ No
3. Do you perform industrial subcontracted work (i.e., manufacturing, packing, assembly)? ☐ Yes ☐ No
   a. If so, what company's label goes on the product? _____
   b. If so, please describe the products: _____
   c. Do any of your products/completed work go into:
      ☐ Aerospace ☐ Watercraft ☐ Sporting Goods ☐ Machinery ☐ Food Products
      ☐ Chemicals or Drugs ☐ Medical Devices ☐ Toys ☐ Children's Furniture/Clothing
   d. Do contracts include a hold harmless clause in favor of the workshop? ☐ Yes ☐ No
   e. Are workshops named as an additional insured on the manufacturer's policy? ☐ Yes ☐ No
   f. Is shredding or other document destruction conducted? ☐ Yes ☐ No
   g. Do you perform any recycling services? ☐ Yes ☐ No
      If yes, please describe: _____
   h. Do you manufacture any wood or plastic products? ☐ Yes ☐ No
4. Do you perform any landscaping or lawn care services? ☐ Yes ☐ No
   a. If so, please provide the number of:
      Site locations: _____ Annual payroll: $_____ Annual Revenues: $_____
   b. Do any sites have exposure to vehicular traffic? ☐ Yes ☐ No
   c. Are all worksites supervised at all times? ☐ Yes ☐ No
5. Do you perform any janitorial services? ☐ Yes ☐ No
   a. If so, please provide the number of:
      Site locations: _____ Annual payroll: $_____ Annual Revenues: $_____
   b. Do you service any rest areas? ☐ Yes ☐ No
      If so, how many? _____
   c. Do clients ever work alone? ☐ Yes ☐ No
   d. Are all worksites supervised at all times? ☐ Yes ☐ No

XIV. RESPITE CARE

☐ N/A

1. In what setting are respite care services provided? ☐ In-Home ☐ Your facility
2. Is an application/vetting process required prior to respite services being provided? ☐ Yes ☐ No
3. What is the staff to client ratio for respite services? _____
4. Do you provide respite services to medically fragile clients? ☐ Yes ☐ No
5. Do you provide respite services to anyone under the age of 18 years of age? ☐ Yes ☐ No

XV. FUNDRAISERS AND SPECIAL EVENTS

☐ N/A

1. Do you place to hold any of the following types of events during the policy period?

☐ Aircraft or airshows ☐ Automobile rallies ☐ Motorcycle rallies or runs
☐ Parades sponsored by the Insured ☐ Political rallies
☐ Events including contact sports ☐ Events involving the use of fireworks
☐ Concerts with admissions of over 500 people ☐ Rodeos
☐ Carnivals and fairs with mechanical rides sponsored by the Insured
☐ Any activity involving animals (other than household pets)
☐ Any event with liquor provided by the Insured where a license is required
☐ Any event lasting more than five (5) days

If you plan to hold any of the event types above, then a Hanover Special Event Questionnaire must be completed.

XVI. MATERIAL CHANGE

If the Applicant discovers or becomes aware of any material change in the information provided in this Questionnaire, notice of such change should be reported in writing to us immediately. Such notification of change may affect any issued policy or coverage quotation(s).

XVII. DECLARATIONS, NOTICES, AND SIGNATURES

The submission of this Questionnaire does not obligate the Insurer to issue or the Applicant to purchase a policy. The Applicant hereby authorizes the Insurer to make any inquiry in connection with this Questionnaire.

The undersigned, acting on behalf of the Applicant, declares that to the best of their knowledge and belief, after reasonable inquiry, the statements set forth in this Questionnaire, and any attachments or documents submitted with it, are true and complete.

The undersigned agree that the information provided in this Questionnaire and any material submitted herewith are the representations of all the Applicants and the basis for issuance of the insurance policy should a policy providing the requested coverage be issued, and that the Insurer will have relied on all such materials in issuing any such policy. Any material submitted with the Questionnaire shall be maintained on file (either electronically or paper) with us.

The information requested in this Questionnaire is for underwriting purposes only and does not constitute notice to the Insurer under any policy, of a Claim or potential Claim.

IMPORTANT: Without prejudice to any other rights and remedies of the Insurer, the Applicant understands and agrees that if any such fact, circumstance or situation exists, whether or not disclosed in response to the question above, any claim or action arising from such fact, circumstance or situation is excluded from coverage under the proposed policy, if issued by the Insurer.

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: 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 Agencies.

FLORIDA AND OKLAHOMA: 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 (of the third degree in FL).

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY, OHIO AND PENNSYLVANIA: 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.

MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: 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 and denial of insurance benefits. *Applies in ME Only.

NEW HAMPSHIRE AND NEW JERSEY: Any person who includes any false or misleading information to the best of her/his knowledge on an application for an insurance policy is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NEW YORK: 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 civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

Note: This application must be signed by the chief executive officer or chief financial officer of the Applicant acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date ***Signature/Title***

_____ _____

(mm/dd/yyyy) (Chief Executive Officer, President, Chief Financial Officer, Managing Partner or Owner)