The Hanover Insurance Group™

HUMAN SERVICES ADVANTAGE
Developmental Disabilities
Underwritten by THE HANOVER INSURANCE COMPANY

Renewal 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

Insured Name: _____ Policy Number: _____

Contact Person: _____ Email: _____

II. UNDERWRITING INFORMATION

1. Have there been any changes in operations this year? ☐ Yes ☐ No

   If yes, describe changes in operations or programs during this past year. Include any changes, additions, deletions of operations, programs, or internal policies, including types of clients served (use additional pages if necessary, reference websites, brochures, etc.).

   _____

   _____

   _____

2. Has there been a change in management this year? ☐ Yes ☐ No
3. If licensed, is your license current and in good standing? ☐ Yes ☐ No
4. Were there any violations or deficiencies noted during the last inspection performed by the licensing agency? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

5. Are you aware of any claims, allegations, and/or incidences (including abuse and molestation) made against your organization, or against anyone working on your behalf in the past five (5) years, that may give rise to a claim? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

III. PROFESSIONAL LIABILITY

1. Do you have any employed, contracted, or volunteer nurse practitioners? ☐ Yes ☐ No

   If yes, how many? _____
2. Do your nurse practitioners prescribe medication? ☐ Yes ☐ No

   If yes, how many nurse practitioners prescribe medication? _____
3. Do your nurse practitioners work in non-medical positions at your organization, such as managers, educators, directors, nursing duties? ☐ Yes ☐ No

If no, please describe duties: _____

_____

4. Does the Insured use employed, contracted, or volunteer Medical Professionals? ☐ Yes ☐ No

If yes, complete the following table for any Psychiatrists, MDs, Nurse Practitioners, Dentists or Optometrists:

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
Does physician/nurse practitioner carry 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, MD, Nurse Practitioner, Dentist or Optometrist

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

_____

6. Please indicate the number of staff in the following table:

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Administrator	_____	_____	_____	_____	_____	_____	_____	_____
Child Case Worker	_____	_____	_____	_____	_____	_____	_____	_____
Clergy	_____	_____	_____	_____	_____	_____	_____	_____
Clerical/Office Staff	_____	_____	_____	_____	_____	_____	_____	_____
Counselor (Other)	_____	_____	_____	_____	_____	_____	_____	_____
Home Health Aide	_____	_____	_____	_____	_____	_____	_____	_____
Nurse Practitioner	_____	_____	_____	_____	_____	_____	_____	_____
Nurse - LPN	_____	_____	_____	_____	_____	_____	_____	_____
Nurse - RN	_____	_____	_____	_____	_____	_____	_____	_____
Nutritionist	_____	_____	_____	_____	_____	_____	_____	_____
Physician	_____	_____	_____	_____	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____	_____	_____	_____	_____
Resident Manager	_____	_____	_____	_____	_____	_____	_____	_____
Social Worker - Bachelors (BSW)	_____	_____	_____	_____	_____	_____	_____	_____
Social Worker - Masters (MSW)	_____	_____	_____	_____	_____	_____	_____	_____

Therapist - Occupational	_____	_____	_____	_____	_____	_____	_____	_____
Therapist - Physical	_____	_____	_____	_____	_____	_____	_____	_____
Therapist - Speech/Hearing	_____	_____	_____	_____	_____	_____	_____	_____
Other Positions: _____ _____ _____	_____	_____	_____	_____	_____	_____	_____	_____

7. Please indicate the annual number of clients in each age range for all programs/services:
   0-8 years: _____ 9-18 years: _____ Over 18 years: _____
8. Professional Liability Deductibles (Optional)
   Please check one: (If no option is selected, no deductible will apply.)
   ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000

IV. RESIDENTIAL SERVICES

☐ N/A

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

LOCATION	Type of Facility	# Beds	# Day Staff	# Night Staff	Level of Client Disability	
					# Mild/ Moderate	# Severe/ Profound

1. Please indicate the annual number of clients in each age range:
   Under 18: _____ 18-65: _____ Over 65: _____
2. How many residents:
   - Have individual care plans that include monitoring food intake due to potential choking hazards? _____
   - Are non-ambulatory? _____
   - Are bed-ridden? _____
   - Have acquired/traumatic brain injuries? _____
   - Have a history of seizures? _____
   - Have dementia/Alzheimer's? _____
   - Display self-injurious behavior? _____
   - Display inappropriate sexual behavior? _____
3. Do any residents require the use of ventilators? ☐ Yes ☐ No
   If so, how many? _____
4. Do any residents require the use of feeding tubes? ☐ Yes ☐ No
   If so, how many? _____
5. Are any residents considered medically fragile? ☐ Yes ☐ No

If so, how many? _____

V. DAY SERVICES

☐ N/A

1. What is the annual number of clients in day programs? _____
2. How many clients in your day programs have:
   - Individual care plans that include monitoring food intake due to potential choking hazards? _____
   - Acquired/traumatic brain injuries? _____
   - A history of seizures? _____
   - Dementia/Alzheimer's? _____

VI. IN-HOME SERVICES

☐ N/A

1. Please indicate the annual number of clients receiving in-home services by age range:
   Under 18: _____ 18-65: _____ Over 65: _____
2. Do you offer skilled nursing services? ☐ Yes ☐ No
   If so, how many employees perform them? _____
3. Please indicate services offered: (Check all that apply.)

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

4. How many clients receiving in-home services:
   - Have individual care plans that include monitoring food intake due to potential choking hazards? _____
   - Are non-ambulatory? _____
   - Are bed-ridden? _____
   - Have acquired/traumatic brain injuries? _____
   - Have a history of seizures? _____
   - Have Dementia/Alzheimer's? _____
   - Display self-injurious behavior? _____
   - Display inappropriate sexual behavior? _____
5. Do any clients require the use of ventilators? ☐ Yes ☐ No
   If so, how many? _____
6. Do any clients require the use of feeding tubes? ☐ Yes ☐ No
   If so, how many? _____
7. Are any clients considered medically fragile? ☐ Yes ☐ No
   If so, how many? _____

VII. 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).

VIII. 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 in any attachments or other 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)