The Hanover Insurance Group™

HUMAN SERVICES ADVANTAGE

Youth Services

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

Applicant Name: _____ Policy Number: _____

Contact Person: _____ Email: _____

1. Has there been any changes in operations or programs during the last year? ☐ Yes ☐ No

   If yes, describe changes in operations or programs, including any additions or deletions of operations/programs, changes to internal policies, including types of clients' service. Please use additional pages in necessary and include any reference websites, brochures, etc.

   _____

   _____

   _____

2. Has there been a change in management this year? ☐ Yes ☐ No

3. If licensed, is your license 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: _____

   _____

II. PROFESSIONAL LIABILITY

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

   If yes, how many? _____

2. If you employ, contract, or accept volunteer nurse practitioners:

   a. Do your nurse practitioners prescribe medication? ☐ Yes ☐ No

If yes, how many of your nurse practitioners prescribe medication? _____

b. Do your nurse practitioners work in non-medical positions at your organization, such as managers, educators, directors, nursing duties? ☐ Yes ☐ No

If yes, describe duties: _____

3. Do you use employed, contracted, or volunteer medical professionals? ☐ Yes ☐ No

If yes, please 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
Carry own Malpractice Insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, does coverage include acts while working for this organization?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, does coverage include contingent coverage for this organization?	☐ 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.

4. 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 HealthAide	_____	_____	_____	_____	_____	_____	_____	_____
Nurse Practitioner	_____	_____	_____	_____	_____	_____	_____	_____
Nurse – LPN	_____	_____	_____	_____	_____	_____	_____	_____
Nurse – RN	_____	_____	_____	_____	_____	_____	_____	_____

Nutritionist								
Physician								
Psychiatrist								
Psychologist								
Resident Manager								
Social Worker - Bachelors (BSW)								
Social Worker - Master (MSW)								
Teacher/Tutor/Aide								
Therapist - Occupational								
Therapist - Physical								
Therapist - Speech/Hearing								
Other Positions: _____ _____ _____								

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

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

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

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

III. 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

2. What is the annual number of residential clients by age? Under 18 _____ 18-65 _____ Over 65: _____
3. Do any residents have a history of starting fires? ☐ Yes ☐ No
4. Do any residents have a history of violent or physically aggressive behavior? ☐ Yes ☐ No
5. Do any residents have a history of sexually aggressive behavior? ☐ Yes ☐ No
6. Do any residents have a history of substance abuse? ☐ Yes ☐ No
7. Do any residents have a history of non-suicidal self-injury? ☐ Yes ☐ No
8. Do any residents have a history of attempted suicide? ☐ Yes ☐ No

9. Do any residents have a history of elopement? ☐ Yes ☐ No
10. Do any residents have an eating disorder? ☐ Yes ☐ No

IV. DAY CARE SERVICES ☐ N/A

1. What is the staff to child ratio? _____:_____
2. Based on the maximum number of children enrolled on your busiest day, what is your actual breakdown of total staff to total number of children by age group (excluding director)?

Infants (ages 0-12 months):	Number of Staff: _____	Number of Children: _____
Toddlers (ages 12-24 months):	Number of Staff: _____	Number of Children: _____
Toddlers (ages 24-36 months):	Number of Staff: _____	Number of Children: _____
Preschool (ages 3-5 years):	Number of Staff: _____	Number of Children: _____
School Aged Children:	Number of Staff: _____	Number of Children: _____

V. FOSTER CARE AND ADOPTION SERVICES ☐ N/A

1. Does your organization provide any adoption or foster care services? ☐ Yes ☐ No
2. What is the annual number of foster care placements?
   Last 12 months: _____ Projected next 12 months: _____
3. What is the annual number of adoption placements?
   Last 12 months: _____ Projected next 12 months: _____

VII. CAMPS ☐ N/A

1. How many days does the camp operate each year? _____
2. What is the average number of campers each day? _____
3. What is the number of campers in each age range?
   Under 12 _____ Ages 13-16 _____ Over 16 _____
4. What is the average number of counselors within each age range?
   16-18 years _____ 18-22 years _____ Over 22 _____

VIII. SPORTS PROGRAMS/LEAGUES ☐ N/A

1. Please confirm which sports programs are offered by your organization:

☐ Archery	☐ Baseball	☐ Basketball	☐ Biking	☐ Cheerleading
☐ Diving	☐ Equestrian	☐ Field Hockey	☐ Football (tackle)	☐ Football (touch or flag)
☐ Gymnastics	☐ Hiking	☐ Ice Hockey	☐ Lacrosse	☐ Martial Arts
☐ Rugby	☐ Skating	☐ Skateboarding	☐ Soccer	☐ Softball
☐ Swimming	☐ Volleyball	☐ Wrestling	☐ Other: _____	

XIV. OTHER RECREATIONAL ACTIVITIES

☐ N/A

1. Please confirm any other recreational activities and/or equipment your organization offers or plans to offer:

☐ Adventure Programs	☐ ATVs/Dirt Bikes	☐ Boating	☐ Caving	☐ Climbing Wall
☐ Inflatable Elements	☐ Horseback Riding	☐ Go-Karts	☐ Lakes/Ponds	☐ Paintball
☐ Rock Climbing	☐ Ropes Courses	☐ Snow Skiing	☐ Snow Tubing/Sledding	
☐ Swimming Pools	☐ Trampolines	☐ Tubing	☐ Water Blobs	☐ Water Skiing
☐ Water Slides over 10 feet in height		☐ Zip Lines	☐ Other: _____	

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. Applicant hereby authorizes the Insurer to make any inquiry in connection with this Questionnaire.

The undersigned, acting on behalf of the Applicant, declare 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)