The Hanover Insurance Group™

HUMAN SERVICES ADVANTAGE

Youth Services

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/CEO: _____

   Number of years in this field: _____ Number of years at this organization: _____
5. Do you operate any licensed facilities? ☐ Yes ☐ No
6. Have any of your licenses ever been under investigation, 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 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 there been any changes in operations this year? ☐ Yes ☐ No

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

   _____
10. Have you ever discontinued any programs? ☐ Yes ☐ No

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

    _____
11. Are you currently accredited by? ☐ JCAHO ☐ CARF ☐ COA ☐ Other:_____

12. 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 all incidents to the administrator? ☐ Yes ☐ No
   a. Are written records of all incidences kept by the administrator and reviewed? ☐ Yes ☐ No
2. Do you have a formal written safety program in place? ☐ Yes ☐ No
3. Do you have a plan in place for medical emergencies? ☐ Yes ☐ No
4. 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 agreement.
5. If you contract for services, are certificates of insurance required and kept on file for those contractors? ☐ Yes ☐ No
   If yes, what are the minimum limits of liability? $_____
6. What type of method do you use for de-escalation of conflicts with patients? _____
7. How often is the staff recertified in the de-escalation of conflicts? _____
8. Are physical interventions used? ☐ Yes ☐ No
   If so, what method(s) do you use? _____
9. Are any prone position holds used? ☐ Yes ☐ No
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: ☐ Subcontracted ☐ Employed # Full Time: _____ # Part Time: _____

14. Please list all locations where security personnel are used: _____

_____

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

16. If subcontracted, do you require the security firm to carry its own liability insurance? ☐ Yes ☐ No

    If yes, what limits do they carry? $_____

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): _____ _____	_____	_____	_____	_____	_____	_____	_____	_____

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, please 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 of direct care 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: _____

_____

11. Does your agency provide any adoption or foster care services? ☐ Yes ☐ No

12. What is the annual number of foster care placements? Last 12 Months: _____ Projected Next 12 Months: _____

13. What is the annual number of adoption placements? Last 12 Months: _____ Projected Next 12 Months: _____

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: _____
Contracted Staff	☐ 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 interactions outside of your organization's programs? ☐ 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 your organization 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: _____ 1-8 passenger vans: _____

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

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 the 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 Report (MVR) 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 to 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 by 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 automobiles to 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 of each 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. EMERGENCY SHELTERS ☐ N/A

1. What are the total number of beds? _____

2. What is the total number of staff? Daytime: _____ Night: _____

3. Are clients screened prior to admittance? ☐ Yes ☐ No

   If so, please explain procedures: _____

4. Do you admit clients under the influence of alcohol or drugs? ☐ Yes ☐ No

5. Do you allow the use of alcohol or drugs at your facility? ☐ Yes ☐ No

IX. 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. 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 7 _____ Ages 7-12 _____ Ages 13-18: _____ Over 18: _____

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. Have any of your clients attempted or committed suicide while under your care? ☐ Yes ☐ No

    If so, please provide details with submission.

18. Do any residents have a history of starting fires? ☐ Yes ☐ No

    If so, how many? _____

19. Do any residents have a history of violent or physically aggressive behavior? ☐ Yes ☐ No

    If so, how many? _____

    Please describe controls to monitor these clients: _____

20. Do any residents have a history of sexually aggressive behavior? ☐ Yes ☐ No

    If so, how many? _____

    Please describe controls to monitor these clients: _____

21. Will you accept clients into your residential program who have a history of sexual abuse toward others? ☐ Yes ☐ No

22. Do any residents have a history of substance abuse? ☐ Yes ☐ No

    If so, how many? _____

23. Do any residents have a history of non-suicidal self-injury? ☐ Yes ☐ No

    If so, how many? _____

24. Do any residents have a history of attempted or committed suicide? ☐ Yes ☐ No

    If so, how many? _____

    Please describe controls to monitor these clients: _____

25. Do any residents have a history of elopement? ☐ Yes ☐ No

    If so, how many? _____

    Please describe controls to monitor these clients: _____

26. Do any residents have an eating disorder? ☐ Yes ☐ No

    If so, how many? _____

    Please describe controls to monitor these clients: _____

X. 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: _____

   Hours of Operation: _____

3. Is the facility licensed by the state? ☐ Yes ☐ No

   If no, please explain: _____

4. What is your licensed capacity? _____

5. What is the current enrollment? _____

6. Has a license to operate ever been denied, suspended, or revoked? ☐ Yes ☐ No
   If yes, please provide details: _____
7. Have you ever been brought up for a compliance hearing? ☐ Yes ☐ No
   If yes, please provide details: _____
8. Are emergency evacuation drills conducted with the children? ☐ Yes ☐ No
9. Does the facility have a security system for entry? ☐ Yes ☐ No
10. Is access into the building limited to doors that are supervised? ☐ Yes ☐ No
11. Is there a written drop-off and pick-up procedure? ☐ Yes ☐ No
12. Does your center exit directly to the outside? ☐ Yes ☐ No
    If so, is it at ground level? ☐ Yes ☐ No
13. Do the bathroom doors lock? ☐ Yes ☐ No
    If yes, can they be unlocked from outside? ☐ Yes ☐ No
14. Are parents free to visit facility at any time? ☐ Yes ☐ No
15. Please indicate if a file containing the following information is maintained for each child:
    a. Immunization records which are updated annually? ☐ Yes ☐ No
    b. Records for each child indicating any unusual conditions the child has? ☐ Yes ☐ No
    c. Signed releases obtained from parents for emergency medical treatment including dispensing of medication? ☐ Yes ☐ No
    d. Written instructions from child's physician for dispensing prescription medication? ☐ Yes ☐ No
    e. Copy of physical exam or medical certificate provided at enrollment? ☐ Yes ☐ No
16. Is corporal punishment practiced? ☐ Yes ☐ No
17. Is there someone trained in First Aid and CPR available at all times? ☐ Yes ☐ No
18. Do you have an accident policy in place? ☐ Yes ☐ No
    If so, is it mandatory for all children? ☐ Yes ☐ No
19. Are field trips conducted? ☐ Yes ☐ No
    a. If yes, please describe transportation: _____
    b. If yes, what is the minimum age of children allowed to participate? _____
    c. Describe field trips anticipated in next 12 months (include frequency, distance, supervision, etc.): _____
    _____
    d. Is written permission/waiver signed by parents for field trips? ☐ Yes ☐ No
20. If your facility includes a playground, please confirm the following:
    a. Is the playground area fenced in? ☐ Yes ☐ No
    b. List play equipment: _____
    c. Is staff present at all times when children are using the play area? ☐ Yes ☐ No
    d. Is the playground equipment properly maintained and inspected on a specified schedule? ☐ Yes ☐ No
    e. Describe playground surfaces and depths: _____

21. Does the center care for children with Special Needs? ☐ Yes ☐ No

If yes, please provide details: _____

22. Do you provide sick child, drop in, overnight, boarding or camp services? ☐ Yes ☐ No

If yes, please explain: _____

XI. COURT APPOINTED SPECIAL ADVOCATES (CASA) ☐ N/A

1. What date did you become a CASA-approved organization? _____
2. Does your organization follow national CASA standards? ☐ Yes ☐ No
3. Has your organization ever been subject to a CASA hearing regarding its services or operations? ☐ Yes ☐ No
4. Is the organization currently under review by CASA? ☐ Yes ☐ No
5. Please confirm the number of:
   CASA Volunteers: _____ Cases Assigned: _____ Average Annual Cases: _____
6. Have you had to terminate any volunteers for cause? ☐ Yes ☐ No

   If so, please explain: _____

XII. CAMPS ☐ N/A

1. Is the camp accredited by: ☐ ACA ☐ CCCA ☐ Other: _____
2. How many days does the camp operate each year? _____
3. What is the average number of campers each day? _____
4. What is the number of campers in each age range? Under 12 _____ Ages 13-16 _____ Over 16 _____
5. What is the average number of counselors within each age range?
   16-18 years _____ 18-22 years _____ Over 22 _____
6. What is the minimum age of a counselor? _____
7. What is the minimum age requirement for a counselor to drive camp vehicles? _____
8. Are staff required to be at least two (2) years older than the clients in camp? ☐ Yes ☐ No
9. Is your camp seasonal? ☐ Yes ☐ No

   If yes, what months do you operate? _____
10. Does a caretaker live at the camp during the off-season? ☐ Yes ☐ No

    If yes, please describe the property controls in place during the off season: _____

    _____
11. Do you work with medically fragile clients? ☐ Yes ☐ No
12. Do you rent your facilities to other organizations? ☐ Yes ☐ No

    If yes, do you:

    a. Provide any supervision of activities? ☐ Yes ☐ No

b. Obtain certificates of insurance when leasing to others? ☐ Yes ☐ No

c. Require they have minimum limits of insurance in place? ☐ Yes ☐ No

If so, what are the minimum limits? $_____

d. Require to be named as an additional insured on the lessee's liability policy? ☐ Yes ☐ No

e. Always have a written contract in place when leasing to others? ☐ Yes ☐ No

13. Do you provide overnight camping? ☐ Yes ☐ No

If yes, please confirm:

a. What is the average length of stay? _____

b. Do all sleeping rooms have smoke detectors? ☐ Yes ☐ No

If so, please indicate the type of smoke detectors: ☐ Battery operated ☐ Hardwired

If battery operated, how often do you check/replace the batteries? _____

c. Do all sleeping rooms have carbon monoxide detectors? ☐ Yes ☐ No

If so, how often do you confirm the functionality of the carbon monoxide detectors? _____

d. If using well water, how often is the water tested? _____

e. What life saving skills are required of counselors? ☐ CPR ☐ First Aid ☐ Other: _____

f. Do you keep a medical history on file for each camper? ☐ Yes ☐ No

g. Are medications dispensed? ☐ Yes ☐ No

If so, who dispenses them? _____

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

XIII. SPORTS PROGRAMS/LEAGUES ☐ N/A

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

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

☐ Other Sport: _____

2. Are liability waivers signed by all participants and/or parents/guardians of all participants? ☐ Yes ☐ No

3. Is accident insurance in place for the participants? ☐ Yes ☐ No

If so, what is the limit? $_____

4. Is someone trained in First Aid always present during practices and games? ☐ Yes ☐ No

5. Do you have written concussion management protocol? ☐ Yes ☐ No

   If so, do you require the parents/guardians to review and acknowledge the written protocol? ☐ Yes ☐ No

XIV. OTHER RECREATIONAL ACTIVITIES

☐ N/A

1. Please confirm any other recreational activities and/or equipment you have or plan on acquiring for your operations:

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

XV. FUNDRAISERS AND SPECIAL EVENTS

☐ N/A

1. Do you plan 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 with contact sports		☐ Events involving the use of firearms
☐ 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.

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)