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Kaplan Risk Services, Inc.
www.kaplanrisk.com

Application For **Social Services Organization**

1. Name of Applicant: _____
   Street: _____
   City: _____ State: _____ Zip: _____
   Applicant's Web Site Address _____

2. Provide full description of operations: _____

3. Obtain and attach literature, brochures and mission statement.

4. Type of entity: ☐ For Profit ☐ Non Profit ☐ Government ☐ Other

5. Number of years in operation: _____ Years under present management: _____
   Licensed by: _____ State licensed in: _____
   Was license ever suspended or revoked? ☐ Yes ☐ No If yes, provide details: _____

6. Primary funding source: _____ Annual payroll: _____

7. Annual operating budget (non profit): _____ Gross sales (for profit): _____

8 Number of clients/customers per year: _____ What is your annual staff turnover rate? _____

9. Are you accredited? ☐ Yes ☐ No If yes, by whom? _____
   Has your organization ever lost accreditation? ☐ Yes ☐ No If yes, provide details: _____

10. Are you a member of any professional organizations? _____

11. Do you sponsor any special fund-raising events? ☐ Yes ☐ No
    Provide full details (location, dates, attendance, description of events, etc.) _____

12. Are alcoholic beverages served? ☐ Yes ☐ No If yes, do you have liquor liability coverage? ☐ Yes ☐ No

13. Have you ever discontinued any programs? ☐ Yes ☐ No If yes, explain: _____

14. Do you provide 24-hour residential care? ☐ Yes ☐ No If yes, complete institutional care application.
    Do you provide counseling services? ☐ Yes ☐ No If yes, complete counseling center application.
    Do you provide childcare services? ☐ Yes ☐ No If yes, complete daycare application.
    Do you operate a camp? ☐ Yes ☐ No If yes, complete camp application.
    Do you operate a foster care program? ☐ Yes ☐ No If yes, complete foster care application.
    Describe the work being performed: _____
    Do you perform any adoption services? ☐ Yes ☐ No If yes, what is the percentage? _____
    Are they domestic or overseas? _____

15. Do you operate or sponsor a rope confidence-building course? ☐ Yes ☐ No
    If yes, provide details: _____

16. Do you operate or sponsor a therapeutic wilderness program for teens that are experiencing emotional/ behavioral problems? ☐ Yes ☐ No If yes, provide details: _____

17. Are you involved in any contracting operations? ☐ Yes ☐ No If yes, provide details: _____

18. Do you provide any legal or financial advocacy services? ☐ Yes ☐ No

19. Do you provide any CASA services? ☐ Yes ☐ No

20. Do you provide supervised visitation services? ☐ Yes ☐ No

21. Complete list of staff: # of employees _____ # of Volunteers _____

Positions	Number Employed	Number Contracted	Number of Volunteers
Physicians			
Psychiatrists			
Psychologists			
Administrators			
Counselors			
Nurses			
Social Workers			
Teachers			
Therapists			
Clergy			
Others (list)			

22. Are certificates of malpractice insurance obtained from all contracted service providers? ☐ Yes ☐ No

23. Do nurses carry their own professional coverage? ☐ Yes ☐ No
If yes, what are the limits carried _____

24. Provide number of participants:

Category	Number	Category	Number
Mental Retardation		Psychiatric Disabilities	
Autistic		Abuse	
Cerebral palsy		Homeless	
Down's Syndrome		Alcohol/Drug	
Elderly		Others (List)	
Brain Injury			

25. Prior insurance carrier and loss history (If none, check here ☐.)

Year	Insurance Company	Policy Number And Premium	Loss Paid & Reserved	Loss Description

26. During the past three years, have any claims been presented to your current carrier? ☐ Yes ☐ No
If yes, provide details including description of claim, amounts paid and reserves: _____

27. Has applicant, or any other person for whom insurance is being requested, result in a claim? ☐ Yes ☐ No
If yes, provide full details: _____

28. Is the applicant, or any other person for whom insurance is being requested, had any liability application denied, policy cancelled or policy not renewed in past three years? ☐ Yes ☐ No
If yes, provide full details: _____

29. Limits of insurance requested:

General Aggregate Limit (Other than Products-Completed Operations)	$ _____	
Products – Completed Operations Aggregate Limit	$ _____	
Personal and Advertising Injury	$ _____	any one person or organization
Each Occurrence Limit	$ _____	
Damage to Premises Rented to You (up to $50,000 limit available)	$ _____	any one premise
Medical Expense Limit (up to $5,000 limit available)	$ _____	any one person
Each Professional Incident Limit (If applicable)	$ _____	

30. Effective Dates Desired: From: _____ To: _____

IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE ANSWER THE FOLLOWING QUESTIONS:

31. Please indicate the Sexual Molestation sublimit wanted:
☐ $25,000/25,000 ☐ $25,000/50,000 ☐ $50,000/50,000 ☐ $50,000/100,000
☐ $100,000/100,000 ☐ $100,000/300,000 ☐ $300,000/300,000

32. Please describe your hiring practices: _____

33. Do you have written guidelines regarding sexual misconduct? ☐ Yes ☐ No

34. What steps have you taken to prevent or avoid a sexual misconduct incident? _____

35. Has any employee or volunteer or other person working for you ever been arrested or convicted of a crime? ☐ Yes ☐ No
If yes, provide details: _____

36. Has your organization had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
If yes, provide details: _____

37. Has any organization that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? ☐ Yes ☐ No
If yes, provide details: _____

Notice to applicants: In most states any person who knowingly and with intent to defraud files an application for insurance containing any materially false information, or conceals for the purpose of misleading information concerning any fact material hereto, commits a fraudulent act, which is a crime.

Applicant's Signature: _____ Date: _____

Title: _____ Producing Agent: _____