Application for Correctional Liability Insurance

Instructions:

1. **Please read the instructions carefully.** Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. **All application questions must be fully answered.** If a question does not apply, please write "N/A".
3. **If more space is needed,** continue on a separate sheet of the applicant's letterhead and indicate the question number.
4. **To this application, please attach copies of:**
   a. Marketing or Advertising brochures or descriptive materials provided to clients.
   b. Latest annual financial statement.
   c. Claim loss runs for the past 5 or more years for all coverages being applied for.
   d. If the applicant is a new business submit professional qualifications (i.e. resume or C.V.) of each owner, partner, officer and key employee.
   e. Operations Manual governing each of the following:

- Administration/security of medication
- Emergency Evacuation of facility
- Inmate grievance procedures
- Intake, Screening & Classification
- Medical Treatment
- Strip Searches
- Suicide prevention and control
- Visual observation of offenders

5. This application must be completed, signed and dated by a principal of the business.

The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate. A separate physician application is required for all physicians requesting coverage under this policy.

I. GENERAL INFORMATION

1. Name of Applicant (Legal Name): _____
2. Physical Address: _____
3. Mailing Address: (if different) _____
4. Corporate Address: (if different) _____
5. City: _____ State: _____ Zip Code: _____ County: _____
6. Corporate Contact: _____ Email Address: _____

   Tel. Number: _____ Fax Number: _____ Website: _____

7. Date Established: _____ ☐ Corporation ☐ Partnership ☐ Professional Association ☐ For Profit ☐ Not for Profit ☐ Individual
8. Licensed? ☐ Yes ☐ No If Yes, indicate type: _____
9. Please specify any professional societies or associations which you are a member: _____
10. Is the firm engaged in, owned by, associated with, or controlled by any other business? ☐ Yes ☐ No
11. Gross Revenue:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Gross Revenue	$	$	$	$	$

12. How many years has the applicant been in operation? _____

13. Within the next twelve month period, does the applicant plan to:

- Obtain another operation or entity? ☐ Yes ☐ No
- Add to the number of employees? ☐ Yes ☐ No
- Expand the number of locations? ☐ Yes ☐ No
- Eliminate/add current services? ☐ Yes ☐ No
- Operate in other states? ☐ Yes ☐ No

If yes, please explain: _____

14. Within the past five years has the applicant acquired, sold or discontinued any operations: ☐ Yes ☐ No

If yes, please explain: _____

Are you interested in a quote for:

a. Medical Professional Liability ☐ Yes ☐ No

b. Employee Benefits Liability ☐ Yes ☐ No

c. Employment Practices Liability ☐ Yes ☐ No

d. Aggregate Per Location Endorsement ☐ Yes ☐ No

e. Excess Liability ☐ Yes ☐ No

Current insurance program:

	Professional Liability	**General Liability**
Policy Year		
Company		
Limits of Liability		
Liability Deductible (if any) or Self-Insured Retention	☐ Deductible $ _____ ☐ SIR $ _____	☐ Deductible $ _____ ☐ SIR $ _____
Claims Made or Occurrence	☐ Claims Made ☐ Occurrence	☐ Claims Made ☐ Occurrence
If Claims Made, Retroactive Date		
Premium		

II. COVERAGE/LIMITS/DEDUCTIBLES

1. Requested Effective Date: _____ Requested Prior Acts Date: _____

2. Requested Limits of Liability: $ _____ per claim $ _____ aggregate

3. Deductible: $ _____ per claim

4. Do you desire excess liability coverage? ☐ Yes ☐ No *If yes, complete this section. If no, complete application.*

   a. Excess Liability requested limit $ _____ per claim, $ _____ aggregate in excess of primary coverage limits.

   b. Have your excess professional or commercial general liability limits been increased within the last five years? ☐ Yes ☐ No

      If yes, what was the prior limit and when was it increased? _____

5. Does a state the applicant is operating in have a Patient Compensation Fund? ☐ Yes ☐ No
   If yes, is the applicant currently enrolled in the Patient Compensation Fund? ☐ Yes ☐ No

6. Has any insurance carrier canceled or refused to renew coverage? ☐ Yes ☐ No
   If yes, please explain: _____

III. OPERATION(S) OVERVIEW

1. a. Please describe your operations: _____

   b. **Please attach all descriptive brochures, marketing materials and/or newsletters.**

2. Please describe your primary occupants or clients: _____

3. Please advise percentage of occupants/clients directed to you by the criminal justice system: _____ %

4. How many separate **Residential Locations** do you operate? _____

5. How many separate **Non-Residential Operations** do you manage? _____

6. How many total employees do you have? Full time: _____ Part time: _____

7. How many total contracted employees do you have? _____

8. List all entities or organizations that need to be included as an additional insured. Please include the affiliation to your organization. Attach an additional sheet if necessary.

9. List any anticipated "Special Events/Fund Raisers" you may sponsor throughout the year:

10. a. Have you ever transferred any debt and/or assets off of its books to a partnership or other independent vehicle?..... ☐ Yes ☐ No

    b. If Yes, please explain the transaction: _____

IV. HIRING/SCREENING/TRAINING PROCEDURES

1. Do your screening/hiring procedures contain any of the following?
   - Educational background ☐ Yes ☐ No
   - Previous employers/employment history ☐ Yes ☐ No (PRIOR to hiring or placement)
   - Personal references ☐ Yes ☐ No
   - How are references checked? ☐ Written ☐ Verbal ☐ Both
   - Hospital privileges for physicians ☐ Yes ☐ No
   - How often do you update your list of specific privileges? _____
   - Pending license suspensions, revocations ☐ Yes ☐ No
   - Pending disciplinary actions by other facilities ☐ Yes ☐ No
   - Criminal background check ☐ County ☐ State ☐ Federal ☐ None
   - Medical professional claims history ☐ Yes ☐ No
   - Background Investigations ☐ Police Reports ☐ Child Abuse Registries ☐ FBI/National Crime Information Center
2. Are each of your hiring procedures indicated above followed and documented? ☐ Yes ☐ No
3. If an individual has had a previous claim, license suspension or revocation, how does that impact your procedures for hiring that person? _____ Are any additional criteria applied? ☐ Yes ☐ No
4. Does your employment application (paid and volunteer) include questions addressing whether the individual has ever been convicted of any crime? ☐ Yes ☐ No If Yes, please explain: _____
5. Does your employment application (paid and volunteer) include a question addressing whether Applicant has ever been found guilty of a violation of professional ethics codes, misconduct, incompetence, negligence, or been required to surrender their license? ☐ Yes ☐ No
6. Do you conduct random drug testing of its entire employed and contract staff? ☐ Yes ☐ No
7. Do you discuss at staff orientation, how to recognize the signs of abuse, and what to do if a client or occupant reports someone abused/molested him/her? ☐ Yes ☐ No
8. What training is provided for new staff (e.g. aides, volunteers, technicians)? _____
9. Do you follow a plan of supervision that monitors staff in day-to-day relationships with clients or occupants? ☐ Yes ☐ No
10. Do you have a written crisis management plan for dealing with staff, victim(s), family (ies), authorities, and media if you have an incident of abuse or death? If Yes, please attach. ☐ Yes ☐ No
11. Do you insist and assure proper training has been received by its employees in conjunction with the following:

Baton/PR-24/ASP ☐ Yes ☐ No	First Aid ☐ Yes ☐ No
Chemical Sprays ☐ Yes ☐ No	Evacuation ☐ Yes ☐ No
Appropriate Restraint Techniques ☐ Yes ☐ No	Emergency Procedures ☐ Yes ☐ No
Suicidal Tendencies ☐ Yes ☐ No	CPR ☐ Yes ☐ No
Non-Violent Crisis Intervention ☐ Yes ☐ No	Abuse Recognition ☐ Yes ☐ No

12. Are formal employee training records maintained? ☐ Yes ☐ No Are they maintained separately from an employee's personnel file? ☐ Yes ☐ No
13. Are written job descriptions established for all employees and volunteers? ☐ Yes ☐ No
14. Before staff can provide care, is a competency based checklist used to assess and document their skills? ☐ Yes ☐ No
15. Briefly describe your standard method and length of training for a new employee or volunteer:

_____

_____

V. PRODUCTS LIABILITY

1. a. Do you or your offenders manufacture, sell, handle, distribute or dispose of any product(s) to outside, unrelated parties? ..... ☐ Yes ☐ No

   b. If Yes, please answer Questions 2-5 below.

2. a. Describe the type and nature of products or goods that you grow, make, remake, assemble, modify, produce, package, install or manufacture:

   _____

   _____

   b. Please provide estimated gross annual sales/receipts generated from the products or goods indicated in 2.a. above: _____

   c. To whom are the products sold or delivered? _____

3. Is the work performed under contract? If Yes, please attach a copy of the contract. ..... ☐ Yes ☐ No

VI. LITIGATION/CLAIMS HISTORY/SANCTIONS/FINES

If the response is yes to any question below, additional information must be provided on the applicant's letterhead. Please submit actual loss runs from the previous carriers for the past five or more years.

1. Has the applicant had any Professional or General Liability claims or suits brought against them in the past five years? ☐ Yes ☐ No
2. Is the applicant aware of any incident (including requests for medical records), circumstance or occurrence which may result in a claim and which has not been reported to another carrier? ☐ Yes ☐ No
3. Has the facility/operations license ever been suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
4. Has any Insurance Company declined, canceled or refused to renew or accept any of the applicant's liability insurance? ☐ Yes ☐ No
5. Has the Company with whom the applicant been previously affiliated with become insolvent? ☐ Yes ☐ No
6. Has any federal or state civil or criminal investigation or action been initiated or filed that directly or indirectly involve the applicant's organization? ☐ Yes ☐ No
7. Has the applicant ever been sanctioned or decertified by Medicare? ☐ Yes ☐ No
8. Has the organization or any of it's officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by federal or state authorities, any professional medical society, accreditation agency or other governmental or non-governmental oversight entity? ☐ Yes ☐ No

Provide the following for each claim, suit or incident (attach additional sheets if necessary):

Date of Accident: _____ Date of Notice: _____

Amount Paid or Reserved: $ _____ Claimant: _____

Insurance Carrier: _____

Allegations: _____

Description of Treatment Rendered: _____

Date of Accident: _____ Date of Notice: _____

Amount Paid or Reserved: $ _____ Claimant: _____

Insurance Carrier: _____

Allegations: _____

Description of Treatment Rendered: _____

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

This application does not bind the Applicant to buy, or the Company to issue the Insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the Company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

SIGNATURE OF APPLICANT X_____ **DATE X** _____

Name: _____ Job Title: _____

(Must be signed by principal partner or officer of group or individual applying for insurance.)

Producer: _____ Phone Number: _____

Producer's Address: _____

Tax I.D. Number: _____

Notice to New York Applicants. 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Note: The professional liability coverage being applied for is Claims Made. If there are questions concerning these coverages, please contact your insurance agent.