



SEXUAL MISCONDUCT APPLICATION FORM

This application must be completed in type or ink by the Applicant. All questions must be answered for a quotation to be given. Blank answers or "N/A" will not be accepted. Please answer "No" or "None" to any such questions. Use separate sheet if needed.

If a material change occurs to any of the answers given below prior to the inception of any insurance, the Applicant must notify the insurer, and at the sole discretion of the insurer, any outstanding questions may be modified or withdrawn.

The particulars, representations and statements contained in this Application, and any other information submitted, are the basis for the proposed insurance and will be considered as incorporated into and constituting part of the proposed certificate and/or policy.

The completion and signing of the Application does not bind the Applicant or the Insurer to a policy or certificate of insurance.

1. Name of Applicant: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Telephone number: _____ Website: _____

(List other locations and/or entities on a separate sheet)

2. Applicant is a: Individual Partnership Corporation (for-profit) Corporation (non-profit)
 Joint Venture Other

If "Other", please describe: _____

3. Nature of Operations: _____

4. Year Operations Began: _____

5. Type of Institution:

Residential Care Educational Custodial Religious (include affiliation) Other (describe)

6. Revenues:

Total expected revenue for the upcoming year: \$ _____

Current Year Estimate: \$ _____

Last Year: \$ _____

Prior Year: \$ _____

7. Staff Breakdown:

Total staff count: _____

Total number with direct client contact: _____

Please provide a breakdown of staff count in grid below:

	Total number (annual)	% Male	% Female	Direct Client Contact Answer "Y" for Yes, "No" for No
Full time employees				
Part time employees				

Clergy				
Teachers				
Volunteers				
Independent Contractors				

8. Annual Turnover Rate: _____

9. Services/Locations:

(If the services operate in multiple cities or states please attach a list that shows where all services operate.)

Number of Locations	Types of Services	Exposure Units (Annual <input type="checkbox"/> or Other <input type="checkbox"/> # of Months _____)		
		Number of Youth	Age Range	Number of Adults
	Schools- Religious			
	Schools- Public			
	Schools- Private, elementary			
	Schools- Private, secondary			
	YMCA			
	Overnight Camps			
	Day Camps			
	Churches/Parishes			
	Sunday Schools			
	Mentoring Programs			
	Janitorial contractors			
	Bus transportation			
	Construction workers			
	Cafeteria food service vendors			
	Airport cargo transportation			
	Other (describe)			
Total		Total		Total

LOSS PREVENTION EFFORTS

10. Check which of the following methods are used in the screening and hiring process for employees and volunteers.

Please attach a copy of any items in bold.

Loss Prevention Methods	Type "Y" for Yes and "No" for No	Employees	Volunteers
a.) Standard Application			
b.) Code of Conduct			
c.) Interview			
Face to face interview			
Standard list of interview questions			
Use behavioral interviewing techniques			
Interview by more than one person			
d.) Reference Checks			
Standard questions for references			
e.) Criminal background check			
f.) Abuse registry check (**Required upon binding)			
g.) Checklist of indicators that may indicate increased risk of abuse			
h.) Other (describe)			

LOSS HISTORY

11. Please furnish the past five year's first dollar loss history for all sexual misconduct claims.

Period	# Claims Reserved	# of Claims Paid	Total Paid Loss	Total Reserved Losses	Total Reserved Expenses
From ___/___ to ___/___					
From ___/___ to ___/___					
From ___/___ to ___/___					
From ___/___ to ___/___					
From ___/___ to ___/___					

12. On a separate sheet of paper, please provide the following information for any sexual misconduct claims.

1. Date of initial misconduct
2. Date claim was brought
3. Description of loss indicating if sexual contact did/did not occur
4. Any amounts paid as damages
5. Amounts reserved
6. Legal/claim handling expense
7. Valuation date
8. Procedures instituted to prevent reoccurrences of previous events

13. Is the Applicant aware of any facts, incidents, circumstances or allegations that may result in claims being made against you?
 Yes No
 (If "Yes", please provide details on a separate sheet of paper.)
14. Has the Applicant, any employee or any volunteer currently seeking coverage been involved in an allegation or claim relating to abuse (sexual or other) or molestation?
 Yes No
 (If "Yes", please provide details on a separate sheet of paper.)
15. Are accused employees removed from client care responsibilities pending the outcome of an investigation?
 Yes No
 If "No", please advise what occurs: _____
16. Does the organization have a written policy prohibiting all those listed in question #7 above from working alone with a single client?
 Yes No
17. For overnight activities, what steps are taken to ensure that client-to-client contact is avoided, i.e. separating male from female sleeping quarters? Please describe:

18. List situations where an employee or volunteer has direct contact with clients in an unsupervised situation without oversight of another staff member (you may list on a separate sheet should you require additional space for this answer):

19. Are staff members, other than employees, directly supervised by an employee when interacting with children or vulnerable adults?
 Yes No
 If "No", please explain when these situations occur and how the interactions are monitored.

20. Do staff members ever have children at their home? Yes No
21. Do staff members ever spend time at the home of children? Yes No
22. If transportation is provided, is there more than one adult present at all times? Yes No
23. Are staff members required to complete annual abuse prevention training? Yes No
24. Does central administration establish, monitor, and enforce policies and procedures across all locations? Yes No
 If "No", please explain: _____
25. Are items below included in the operations handbook for all staff members listed in question #7 above?
 Yes No A zero tolerance statement for sexual abuse perpetrated on children or other vulnerable persons in the Applicant's care. (Please attach a copy.)
 Yes No A written policy that defines appropriate and inappropriate displays of affection. (Please attach a copy.)
 Yes No A written procedure for governing the interactions between employees/volunteers and children or other vulnerable persons in your care outside of regular program activities. (Please attach a copy.)
 Yes No A written procedure for managing the risk when one employee/volunteer is a lone child or other vulnerable person. (Please attach a copy.)

26. Does senior management review and approve in writing new care programs?

Yes No

HISTORICAL ACTIVITY

27. Have any of the individuals been transferred in or out of your school, parish/diocese, branch or corporate location because they were involved, suspected, or a complaint was made regarding an allegation of sexual misconduct?

Yes No

(If "Yes", please provide details on a separate sheet of paper.)

28. In the past 10 years, have any individuals been terminated for cause related to abuse (sexual or not) behavior?

Yes No

(If "Yes", please provide details on a separate sheet of paper.)

29. Has the Applicant merged with any other entity in the past 10 years?

Yes No

(If "Yes", please provide details on a separate sheet of paper.)

30. Is the Applicant contemplating a merger in the next 18 months?

Yes No

(If "Yes", please provide details on a separate sheet of paper.)

31. Does the Applicant plan to add any additional care programs in the next year?

Yes No

(If "Yes", please provide details on a separate sheet of paper.)

CLAIMS HANDLING

32. Does the Applicant have a written procedure to allow victims to report abuse?

Yes No

If "Yes", please explain: _____

33. Does the Applicant have a written procedure for responding to reports of suspicious or inappropriate behaviors? Allegations of abuse?

Yes No

If yes, please attach a copy.

34. Does the Applicant have a designated investigator with specialized training who is in charge of handling all internal sexual misconduct investigations?

Yes No

35. Does the Applicant use a standardized incident reporting form across all locations and programs?

Yes No

If "Yes", please attach a copy.

36. Coverage Desired:

Desired Limit of Liability: _____ Desired Retention: _____

37. Reason coverage is desired: _____

38. Prior Sexual Misconduct Liability Insurance Coverage for the past five years, please list the most recent first:

Period	Claims Made or Occurrence	Insurer	Premium	Limit	Sir
From ___/___ to ___/___					
From ___/___ to ___/___					
From ___/___ to ___/___					
From ___/___ to ___/___					
From ___/___ to ___/___					

39. Has any Applicant ever canceled or non-renewed this type of coverage?

Yes No

(If "Yes", please identify the provider and explain the reason for non-renewal on a separate sheet of paper.)

SIGNATURE PAGE

The undersigned warrants and represents that, to the best of his or her knowledge, the statements herein are true and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application. It is represented that the particulars and statements contained in the Application, and any materials submitted (which shall be on file with the insurer and shall be deemed attached, as if physically attached) are the basis for the proposed insurance and are to be considered incorporated into and constituting a part of the proposed insurance.

The undersigned agrees that in the event this Application contains misrepresentations or fails to state facts materially affecting the risk assumed by the insurer, any insurance issued shall be void in its entirety.

The undersigned agrees that if after the date of this Application and prior to issuance of any insurance, any occurrence, event or other circumstance should render any information contained in this Application inaccurate or incomplete, the undersigned shall notify the insurer of such occurrence, event or circumstance and shall provide the Insurer with information that would complete, update or correct the information contained in this Application. Any outstanding quotations may be modified or withdrawn at the sole discretion of the insurer.

The insurer is hereby authorized to make any investigation and inquiry in connection with this Application as it may deem necessary.

Signature of Applicant: _____ Title: _____ Date: _____

Name of Broker: _____

Address: _____ City: _____

State: _____ Zip: _____ Tel: _____ Fax: _____

Note: Applicable surplus line tax is payable by the assured in addition to the premium.