



**PUBLIC RISK
UNDERWRITERS**

SCHOOL PROGRAM

SUBMISSION REQUIREMENTS:

- *School Information per attached applications, Submitting Agency, Proposed Effective Date, Bid Date and Pricing Guidelines*
- *Accord Applications for each line of coverage requested. The property Schedule of Values should include the following:*
 - *square footage*
 - *year built*
 - *construction type*
 - *fire protection class*
 - *note: schools with >20% of blanket value in PC9 and PC10 are ineligible for the program*
- *Supplemental Applications for each line of coverage requested*
- *Currently valued loss runs for current period plus 3 prior periods*

SCHOOL PROSPECT FORM

I. APPLICATION INFORMATION

- A. Name Insured _____
- B. Address _____ City _____
County _____ State _____ Zip Code _____
Phone: _____ Population (include resident students) _____
- C. Contact for inspection _____ email: _____

II. SUBMITTING AGENCY INFORMATION

- A. Agency Name _____
- B. Address _____ City _____ State _____ Zip Code _____
- C. Phone _____ Facsimile No _____
- D. Agent/Broker _____ Email: _____

III. PROPOSED EFFECTIVE DATE _____ BID DATE _____

IV. COVERAGE CARRIER PREMIUM X-DATE NOTES

- Genl Liab _____
- E & O _____
- Law _____
- Auto _____
- Prop _____
- I M _____
- B & M _____
- Umbr _____
- Other _____

PROPERTY INFORMATION

Yes No

- 1. How were school property values determined?
 - a. Professional appraisal By _____ When _____
 - b. Other _____ When _____
- 2. Are there presently any buildings with roofs over 20 years old?
Which buildings?

- 3. Does the district have a written roof replacement and repair management plan to track the condition of all roofs?
- 4. Frequency of roof inspections? Monthly Quarterly Annually Other _____
 Performed by professional contractor Performed by school employee(s)
- 5. Does the plan include scheduled maintenance?
- 6. Do maintenance records include the following; *check any that apply*:
 date of repair description of repair
 contractor/individual who performed repair contractor's certificate of insurance
- 7. Is there a policy in place prohibiting the acceptance of donated paints, solvents, fertilizer, herbicides, pesticides, or other chemicals?
- 8. Is there a chemical purchasing policy in place to limit the quantities purchased to a maximum of a two year supply?
- 9. Does the district have a chemical management program that specifies: *check any that apply*:
 how and where chemicals are stored, tracks the quantities and ages of chemicals, and
 specifies how chemicals and waste are to be disposed?
- 10. Is the use of space heaters restricted in all school buildings?
- 11. Is smoking prohibited in all school buildings?
- 12. Do all cooking areas meet UL-300 standards?
 Are contracts in place for extinguishing system and hood/duct cleaning?
- 13. Are all flammables properly stored in UL approved metal cabinets?
- 14. Is woodworking performed in any building(s)? If yes, specify the building(s)

- 15. Is welding or spray painting performed in any building(s)? If yes, specify the building(s)

- 16. Are all areas with cooking, woodworking, chemistry lab or auto repair equipped with outside ventilation?
- 17. Are any buildings presently vacant or unoccupied? If yes, identify building and describe plans for use:

- 18. Are any buildings presently under construction or renovation? If yes, describe project (including cost & length of time):

- 19. Identify all building protected by central station fire alarms:

- 20. Identify all building protected by central station burglary alarms:

- 21. Provide any other information on security that applies to this school district:

GENERAL LIABILITY INFORMATION

Yes No

1. **Indicate any of the following steps implemented as part of a formal safety program:**

Copies should be provided or available at time of inspection.

- Written safety program on use of machinery – provided to all students and staff
- Shop/Lab inspections with unsafe conditions identified and corrections documented
- First aid materials present in each shop/lab
- Periodic inspections of interior/exterior walking surfaces – Frequency _____
- Snow and ice removal procedures
- Visitor sign in procedures
- Bleacher/Grandstand inspections – Frequency _____
- Playground Equipment maintenance & surface protection – Frequency _____
- Quality control measures for food preparation/storage
- Physician, EMT, or other medical service providers present at all athletic events
- Written Discipline policy – provided to all students and staff
- Written Sexual Abuse policy – provided to all employees, volunteers and students
- Written employment policy requiring background checks on all employees
- Written policy requiring background checks on all volunteers

2. Does your employment application ask if the applicant has ever been convicted of any crime, including sex-related or abuse related offenses?

3. Have any of your employees or volunteer workers ever been convicted or had a claim for damages brought against them for sexual misconduct? If yes, provide complete details.

 4. Have you ever had an incident which resulted in an allegation of sexual abuse? If yes, please describe.

 5. Do you have procedures in place to monitor employee and volunteer worker relationships with students, other employees, or other volunteer workers?

6. Are there buildings or dwellings rented to others? If yes, describe.

 7. Is there land rented to others? If yes, describe (including acreage).

 8. Are certificates of insurance required from all contractors doing work on school premises?

- a. Are copies maintained?
- b. Describe work performed.

 9. Swimming Pool? **If yes, Supplement CG8077 is required**

Is pool available to the public or for rent? Frequency _____

10. Has asbestos, lead or toxic mold been detected in any school building? If yes, describe corrective actions.

GENERAL LIABILITY INFORMATION (cont'd)

Yes No

- 11. Does the school district have any written plans designed to address mold?
- 12. Are you aware of the EPA Tools for Schools program designed to address indoor air quality? (<http://www.epa.gov/iaq/schools/tools4s2.html>)
 Have you implemented any parts of this plan?
- 13. Does this district have a Daycare, Early Learning program, or Latch key program?
If yes, complete Supplemental Application CG8097.
- 14. Does your school sponsor any special activities or allow them to be held on your premises? **If yes, Supplement CG8211 is required** (add'l premium may apply).
- 15. Any school sponsored field trips/activities to destinations beyond 50 miles? **If yes, please provide a complete list and include the number of students, method of transportation, and supervision provided.**

16. Indicate if any school programs or clubs involve any of the following activities:

- Skiing Use of guns Archery
- Sky Diving Foreign travel Horseback riding
- Trampoline use Camping/Hiking Rock climbing
- Scuba Diving Whitewater rafting Other, please describe _____

17. Does school require additional insured status & certificates of insurance for non-school related use of facilities by outside parties? Describe use including name of group(s) and frequency:

18. Is additional insured status being requested for any clubs, associations, or organizations affiliated with the school that are to be added to this policy? **If yes, complete CG8050** (additional premium may apply).

19. Do students produce any products for sale or auction to the public? Describe any "yes" responses (including a description of the product and approximate number produced)

20. Is any of the following work performed for outside entities?
 Auto repair Construction-off premises Other _____

21. Are there owned outdoor bleachers or grandstands? If yes, provide the location, and capacity for each.

Location	Seating capacity
_____	_____
_____	_____
_____	_____
_____	_____

AUTO – SCHOOL BUS INFORMATION

Yes No

1. Are school buses used for student transportation to/from all extra curricular activities?
If no, who provides the transportation? _____
If yes, please complete the following:
a. Number of trips each year beyond 150 miles: _____
b. Destinations beyond 150 miles: _____
c. Maximum round trip miles: _____
- d. Do you always use regular drivers? If no, who and when?

2. Are buses used for non-school activities? If yes, list non-school functions/activities?

- Do you furnish drivers? If not, who?
3. Describe driver hiring practices, such as pre-hire MVR checks, experience, age:

4. Where are buses stored when not in use?

Describe protection (fenced, exterior lighting, watchman):

5. Is driver training offered?
 Are students allowed to drive any vehicle other than driver training vehicles? If yes, please explain.

6. Are autos or buses hired by your institution? If yes, please complete.
Estimated annual cost of hire: Buses \$ _____ Autos \$ _____
Name and Address of each independent contractor hired.

7. Do you obtain an Additional Insured form and a Certificate of Insurance from the insurance carrier of each independent contractor?
8. Do you have MVR's checked on all drivers of independent contractors?

CONTRACTORS **NOT APPLICABLE**

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)				Y / N
1. DOES APPLICANT DRAW PLANS, DESIGNS, OR SPECIFICATIONS FOR OTHERS?				
2. DO ANY OPERATIONS INCLUDE BLASTING OR UTILIZE OR STORE EXPLOSIVE MATERIAL?				
3. DO ANY OPERATIONS INCLUDE EXCAVATION, TUNNELING, UNDERGROUND WORK OR EARTH MOVING?				
4. DO YOUR SUBCONTRACTORS CARRY COVERAGES OR LIMITS LESS THAN YOURS?				
5. ARE SUBCONTRACTORS ALLOWED TO WORK WITHOUT PROVIDING YOU WITH A CERTIFICATE OF INSURANCE?				
6. DOES APPLICANT LEASE EQUIPMENT TO OTHERS WITH OR WITHOUT OPERATORS?				
DESCRIBE THE TYPE OF WORK SUBCONTRACTED	\$ PAID TO SUB-CONTRACTORS:	% OF WORK SUBCONTRACTED:	# FULL-TIME STAFF:	# PART-TIME STAFF:

PRODUCTS / COMPLETED OPERATIONS

PRODUCTS	ANNUAL GROSS SALES	# OF UNITS	TIME IN MARKET	EXPECTED LIFE	INTENDED USE	PRINCIPAL COMPONENTS

EXPLAIN ALL "YES" RESPONSES (For all past or present products or operations) PLEASE ATTACH LITERATURE, BROCHURES, LABELS, WARNINGS, ETC.				Y / N
1. DOES APPLICANT INSTALL, SERVICE OR DEMONSTRATE PRODUCTS?				
2. FOREIGN PRODUCTS SOLD, DISTRIBUTED, USED AS COMPONENTS? (If "YES", attach ACORD 815)				
3. RESEARCH AND DEVELOPMENT CONDUCTED OR NEW PRODUCTS PLANNED?				
4. GUARANTEES, WARRANTIES, HOLD HARMLESS AGREEMENTS?				
5. PRODUCTS RELATED TO AIRCRAFT/SPACE INDUSTRY?				
6. PRODUCTS RECALLED, DISCONTINUED, CHANGED?				
7. PRODUCTS OF OTHERS SOLD OR RE-PACKAGED UNDER APPLICANT LABEL?				
8. PRODUCTS UNDER LABEL OF OTHERS?				
9. VENDORS COVERAGE REQUIRED?				
10. DOES ANY NAMED INSURED SELL TO OTHER NAMED INSURED?				

ADDITIONAL INTEREST / CERTIFICATE RECIPIENT

ACORD 45 attached for additional names

INTEREST <input type="checkbox"/> ADDITIONAL INSURED <input type="checkbox"/> EMPLOYEE AS LESSOR <input type="checkbox"/> LIENHOLDER <input type="checkbox"/> LOSS PAYEE <input type="checkbox"/> MORTGAGEE	NAME AND ADDRESS	RANK:	EVIDENCE:	CERTIFICATE	INTEREST IN ITEM NUMBER	
					LOCATION:	BUILDING:
					ITEM CLASS:	ITEM:
					ITEM DESCRIPTION	
		REFERENCE / LOAN #:				

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)	Y / N
1. ANY MEDICAL FACILITIES PROVIDED OR MEDICAL PROFESSIONALS EMPLOYED OR CONTRACTED?	
2. ANY EXPOSURE TO RADIOACTIVE/NUCLEAR MATERIALS?	
3. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	
4. ANY OPERATIONS SOLD, ACQUIRED, OR DISCONTINUED IN LAST FIVE (5) YEARS?	
5. MACHINERY OR EQUIPMENT LOANED OR RENTED TO OTHERS?	
6. ANY WATERCRAFT, DOCKS, FLOATS OWNED, HIRED OR LEASED?	
7. ANY PARKING FACILITIES OWNED/RENTED?	
8. IS A FEE CHARGED FOR PARKING?	
9. RECREATION FACILITIES PROVIDED?	
10. IS THERE A SWIMMING POOL ON THE PREMISES?	
11. SPORTING OR SOCIAL EVENTS SPONSORED?	
12. ANY STRUCTURAL ALTERATIONS CONTEMPLATED?	
13. ANY DEMOLITION EXPOSURE CONTEMPLATED?	
14. HAS APPLICANT BEEN ACTIVE IN OR IS CURRENTLY ACTIVE IN JOINT VENTURES?	
15. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)	Y / N
16. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS OR SUBSIDIARIES?	
17. ARE DAY CARE FACILITIES OPERATED OR CONTROLLED?	
18. HAVE ANY CRIMES OCCURRED OR BEEN ATTEMPTED ON YOUR PREMISES WITHIN THE LAST THREE (3) YEARS?	
19. IS THERE A FORMAL, WRITTEN SAFETY AND SECURITY POLICY IN EFFECT?	
20. DOES THE BUSINESSES' PROMOTIONAL LITERATURE MAKE ANY REPRESENTATIONS ABOUT THE SAFETY OR SECURITY OF THE PREMISES?	

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

IN FLORIDA, 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 MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN 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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.



SCHOOL APPLICATION – LINEBACKER PUBLIC OFFICIALS AND EMPLOYMENT PRACTICES LIABILITY

Date

Producer: Public Risk Underwriters of Indiana, LLC
Name and Mailing Address:
Website Address:
Effective Date:
Expiration Date:
Policy/Account Number:

APPLICANT INFORMATION

- 1. The School District has continuously been in existence since:
2. A. Total current budget — \$
B. Total accumulated deficit — \$ or surplus — \$
C. Explain any budget deficits/surplus and steps taken to eliminate deficit.
D. Current student enrollment:
E. Number of Board Members:
F. List any subsidiary or ancillary boards or committees and describe relationship with applicant, i.e., funding, degree of autonomy, etc., from applicant.

YES NO

Grid of checkboxes for optional coverages/restrictions

- 3. Optional coverages/restrictions on Linebacker Policy:
Board Members and Organization Only as Insureds
Loss of Salary and Fringe Benefits (subject to availability)
Professional Liability

OPERATIONS

YES NO

Grid of checkboxes for operational questions

- 1. Does the School District have a written administrative procedure to assure compliance with the federal law pertaining to student records – right of privacy?
2. Is the School District involved in any disputes regarding integration, segregation or school busing?
3. Has any School been closed or School Activities disrupted during the past three (3) years due to Student or Teacher strikes or actions?
4. Does the School District have special education programs and/or facilities for the developmentally, mentally, emotionally or physically disabled?
5. Do you have written policies and procedures for the following as they pertain to Students?
Suspension?
Expulsion?
Corporal Punishment?
Possession of Weapons?
Drug Testing and Searches?
Sexual Misconduct?
Bullying?

OPERATIONS (Cont'd)

YES NO

- 6. Has the School District established written guidelines for reporting and investigating allegations of harassment (including sexual harassment) brought by students?
- 7. Has the School District developed written guidelines for reporting instances of suspected child abuse to proper authorities?
- 8. Does the School District plan to merge with another school within the next three years? If yes, explain.

- 9. Has any School District bond proposal been defeated by voters within the past three years?
 If yes, was or will a modified proposal be submitted?
- 10. Does the School District do any data processing or computer software development for others?

EMPLOYMENT PRACTICES AND PROCEDURES

YES NO

- 1. Do you have a human resources coordinator or someone responsible for employment matters?
If no, who is responsible for employment matters? _____
- 2. Do you have a written employment manual including all personnel policies and procedures?
 Is it distributed to all employees?
- 3. Does the employee manual include a reservation of rights to change/modify/terminate policies?
- 4. Does the manual ask the employee to sign a receipt acknowledging they have received and understand the manual?
- 5. Is the manual reviewed by counsel experienced and qualified in employment law?
- 6. Do you have a written policy with respect to sexual and non-sexual harassment?
- 7. Do you have a formal written procedure for employee disputes/complaints?
- 8. Do you have a written progressive disciplinary procedure?
- 9. Have any complaints been filed with the EEOC within the last 3 years? If yes, explain.

- 10. Has any employee, former employee, or job applicant made claim against the School District for this insurance or any of its officials or employees within the past three years alleging unfair or improper treatment in connection with any job? If yes, explain.

- 11. Has any official or employee been involuntarily dismissed from employment in the past 3 years or are any staff reductions anticipated in the next twelve months? If yes, explain.

- 12. Does the School District consult with its Human Resources Department or outside counsel prior to dismissing any employee?
- 13. Is a criminal background check completed on all employees?

INSURANCE INFORMATION

YES NO

- 1. Are there any pending or ongoing claims against anyone for whom insurance is intended hereunder which may fall within the scope of this proposed or similar insurance currently in effect or applied for, not previously described in this application? (If answer is none, so state) (If yes, explain.)

- 2. Has any similar insurance on behalf of the School District been declined, cancelled or renewal thereof refused, except as follows (If answer is none, so state)/(Not applicable in MO):

INSURANCE INFORMATION (Cont'd)

YES NO

3. The school district, board and/or its employees are not cognizant of any act, error or omission, or any Federal, State or Local legal actions which they have reason to suppose might afford valid grounds for a future claim which may fall within the scope of the proposed insurance, except as follows: (If answer is none, so state).

4. Does the School District require all sub-contractors or independent consultants to carry liability insurance?

Does the School District request to be added as an additional insured to such liability insurance?

5. The following Named Individual is authorized and designated to receive any and all notices from the Company or its authorized representative(s) concerning this proposed insurance:

6. Previous Insurers' for this type of coverage for each of the last three years:

Company _____	Limit _____	Premium _____
Company _____	Limit _____	Premium _____
Company _____	Limit _____	Premium _____

Previous coverage was: Claims Made Occurrence

If claims made: A. What extended reporting period coverage is available? _____

B. Will you be purchasing extended reporting period coverage?

C. What was the retroactive date (if any) on the expiring policy? _____

7. Does the School District currently carry Commercial General Liability insurance?

8. Policy Limits desired: **Each Loss** **Aggregate Each Policy Year**

\$ 100,000	\$ 1,000,000	<input type="checkbox"/>
\$ 250,000	\$ 1,000,000	<input type="checkbox"/>
\$ 500,000	\$ 1,000,000	<input type="checkbox"/>
\$1,000,000	\$ 1,000,000	<input type="checkbox"/>
\$1,000,000	\$ 2,000,000	<input type="checkbox"/>

DECLARATION AND ATTESTATION

The policy will be subject to a deductible, which can be consumed by either losses, defense costs paid by the Company, or costs paid by the applicant, but subject to the Company's knowledge and consent. The amount of the deductible will vary in accordance with the table of premiums and deductibles filed on behalf of the Company with the Insurance Department.

The authorized signer of this application represents or warrants to the best of his or her knowledge and belief that the statements set forth herein are true and include all material information. The authorized signer also represents or warrants that any fact, circumstance or situation indicating the probability of a claim or action now known to any entity official or employee has been declared, and it is agreed by all concerned that omission of such information shall exclude any such claim or action from coverage under the insurance being applied for. Signing of this application does not bind the insurance company to offer nor the authorized signer to accept insurance, but it is agreed this application and any attachments thereto shall be the basis of the insurance and will be incorporated by reference and made a part of the policy should a policy be issued.

This application provides the Company with certain indicators as to under writing acceptability. It does not provide information on policy coverages nor does it alter the terms of the policy.

Applicant _____

Signed _____
 Authorized School Representative Title Date

Submitted by _____
 Agent Date

**APPLICABLE IN
AL, GA, ID, IL, IN, IA, KS, MS, MO, MT, NH, NC, ND, PA, RI, SD, TN, WI AND WY**

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 the person to criminal and civil penalties.

APPLICABLE IN ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN 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.

APPLICABLE IN FLORIDA

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.

APPLICABLE IN KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

APPLICABLE IN MICHIGAN

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000.00.

APPLICABLE IN MINNESOTA

Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEBRASKA

Any person who knowingly and with intent to defraud any insurance company or another 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 may subject the person to criminal and civil penalties.

APPLICABLE IN NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN 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 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.

APPLICABLE IN OHIO

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA

Any person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud which is a felony.

APPLICABLE IN OREGON

Any person who knowingly and with intent to defraud any insurance company or another 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 may subject the person to criminal and civil penalties.

Applicant's Signature

Date



EMPLOYEE BENEFITS LIABILITY COVERAGE APPLICATION – OCCURRENCE

Date

Producer Public Risk Underwriters of Indiana, LLC P.O. Box 1247 Kokomo, IN 46903-1247 Code Subcode	Name and Mailing Address: Website Address: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Effective Date</td> <td style="width: 25%;">Expiration Date</td> <td style="width: 50%;">Policy/Account Number:</td> </tr> </table>	Effective Date	Expiration Date	Policy/Account Number:
Effective Date	Expiration Date	Policy/Account Number:		

1. List existing EMC Insurance Companies Commercial Lines policy numbers and effective dates. If none, state "none".

2. Number of employees: In U.S. _____; In Canada _____; If any employees are stationed outside of the U.S. or Canada, list location and number at each location: _____

3. Limits for this coverage apply each employee/annual aggregate. Check the limit desired.

- \$300,000/\$300,000
 \$500,000/\$1,000,000
 \$1,000,000/\$2,000,000
 \$500,000/\$500,000
 \$1,000,000/\$1,000,000
 \$1,000,000/\$3,000,000

4. Deductible – Each Employee: \$0 \$100 \$250 \$500 \$1,000

5. Check the Employee Benefit programs or plans that you have available:

- | | | |
|--|---|---|
| <input type="checkbox"/> Group Life Insurance | <input type="checkbox"/> Employee Stock Ownership Plans | <input type="checkbox"/> Leave of Absence Programs including: |
| <input type="checkbox"/> Group Accident Insurance | <input type="checkbox"/> Pension Plans | <input type="checkbox"/> Military Leave |
| <input type="checkbox"/> Group Health Insurance including: | <input type="checkbox"/> Stock Subscription Plans | <input type="checkbox"/> Maternity Leave |
| <input type="checkbox"/> Prescription Drug coverage | <input type="checkbox"/> Unemployment Insurance | <input type="checkbox"/> Family Leave |
| <input type="checkbox"/> Hearing coverage | <input type="checkbox"/> Social Security Benefits | <input type="checkbox"/> Civil Leave |
| <input type="checkbox"/> Vision coverage | <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Other (Please describe below) |
| <input type="checkbox"/> Group Dental Insurance | <input type="checkbox"/> Disability Benefits | <input type="checkbox"/> Subsidies including: |
| <input type="checkbox"/> Flexible Spending Accounts | <input type="checkbox"/> Vacation Plans including: | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Profit Sharing Plans | <input type="checkbox"/> Buy and Sell Programs | <input type="checkbox"/> Health Club |
| <input type="checkbox"/> Employee Sharing Plans | <input type="checkbox"/> Tuition Assistance Plans | <input type="checkbox"/> Other (Please describe below) |
| <input type="checkbox"/> Individual Retirement Account (IRA) Plans | | <input type="checkbox"/> Other (Please describe below) |

Describe "other" plans or programs here.

Employers Mutual Casualty Company EMCASCO Insurance Company	Hamilton Mutual Insurance Company EMC Property & Casualty Company Dakota Fire Insurance Company	Union Insurance Company of Providence Illinois EMCASCO Insurance Company
--	---	---



Yes No

6. a. Was prior Employee Benefit Liability coverage purchased by the applicant? If yes, please complete the following:
Prior Carrier (s) and Policy Term (s) _____

- b. Was prior coverage on a claims-made basis? If yes, please complete the following:
Prior coverage effective date _____ Prior policy retroactive date _____
7. During the past five years, has an employee benefit loss been sustained or is any pending against the Applicant?
If yes, describe:

8. Is a designated person or department available to answer questions and advise employees concerning their Employee Benefit Program?
If yes, who? _____
 Human Resources Department Owner(s) of the business Department Manager
 Immediate Supervisor Others (please describe below)
Describe "Others" here:

9. If multiple locations exist, is administration centralized? If not, please explain.

10. On programs permitting employees an option to enroll or not to enroll, does the Applicant require a signed acceptance or rejection from each employee?
- a. Are all non-participating employees given an annual written offer and opportunity to enroll in optional programs?
- b. Is documentation of all enrollment offers retained permanently?
11. Is a benefit brochure or written explanation of the Employee Benefits Program given to each employee?
 If yes, does the employee acknowledge in writing that he/she has received and reviewed the brochure or written explanation?
12. Does the applicant offer in writing to extend benefits to terminated employees?
 If yes, is this acceptance or rejection in writing and retained permanently?
13. Is the applicant subject to the Employee Retirement Income Security Act of 1974 (ERISA)?
14. Does the applicant have a Fiduciary Liability Policy? Carrier: _____ Limits _____
- a. Is coverage on a claims-made basis?
Policy dates _____ Retroactive date _____
- b. Does the Fiduciary Liability Insurance Policy automatically include or can it be endorsed to provide coverage for the administration of Employee Benefits Programs?

GENERAL FRAUD STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR, VT or WA; in DC, LA, ME, TN and VA, insurance benefits may also be denied)

IN 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

IN FLORIDA, 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 HAWAII FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN OHIO ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

WARNING: IN OKLAHOMA ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

IN 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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

BY SIGNING THIS APPLICATION, THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE THE STATEMENTS SET FORTH HEREIN ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT TO PURCHASE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

Applicant's Signature

Date

Producer's Signature



GOVERNMENTAL SUBDIVISION PRIOR ACTS QUESTIONNAIRE

(Commercial General Liability, Commercial Auto Liability, Employee Benefit Liability, Linebacker/Law Enforcement)

Date

Producer Public Risk Underwriters of Indiana, LLC P.O. Box 1247 Kokomo, IN 46903-1247		Insured Name and Mailing Address:		
Code	Subcode	Website Address: Effective Date		Expiration Date
		Policy/Account Number:		

1. Does Applicant know of any claim that has been made and/or is now pending which was not covered by the previous insurer(s) but could be covered under the scope of this insurance? Yes No

If yes, please describe:

2. Does the Applicant have any knowledge of an occurrence, which might result in a future claim under the scope of this insurance? Yes No

If yes, please describe:

3. Have you notified the previous insurer(s) in writing with details of all known claims as well as incidences which might lead to future claims within the scope of this insurance? Yes No

If no, please explain:

4. Prior Carrier(s)	CA Coverage	CGL Coverage	EBL Coverage	Linebacker/Law Enf.
a. Name of prior carrier	_____	_____	_____	_____
b. Policy Limits	_____	_____	_____	_____
c. Prior coverage eff/exp. date	_____	_____	_____	_____
d. Prior policy retroactive date	_____	_____	_____	_____
e. First year in claims made	_____	_____	_____	_____
f. What extended reporting period coverage is available?	_____	_____	_____	_____
g. Proposed retroactive date	_____	_____	_____	_____

The undersigned authorized officials of the applicant's governing body declare that to the best of their knowledge the statements set forth herein are true. The undersigned agrees that if the information supplied on this questionnaire changes between the date of this questionnaire and the effective date of the insurance, the undersigned 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 any insurance.

Signing of this questionnaire does not bind the undersigned to purchase insurance, but it is agreed that this questionnaire shall be a basis for the contract should a policy be issued.

This questionnaire provides the Company with certain indicators as to underwriting acceptability. It does not provide information on policy coverages nor does it alter the terms of the policy.

Applicant _____

Signed _____

Presiding Official

Date

Signed _____

Secretary

Date

DATA COMPROMISE QUESTIONNAIRE

Date

Producer Public Risk Underwriters of Indiana, LLC P.O. Box 1247 Kokomo, IN 46903-1247		Insured Name and Mailing Address: Website Address		
Code	Subcode	Effective Date	Expiration Date	Policy/Account Number:

Please complete the questions below if any of the following apply:

If the applicant is requesting a 100,000 limit complete questions 1, 2 and 3.

If the applicant is requesting a \$250,000 limit complete questions 1 thru 5.

If the applicant is a Municipality complete all of the questions.

Please indicate whether each of the following apply to the applicant's information security procedures.

Yes No

- | | | | |
|--------------------------|--------------------------|----|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. | Has the applicant suffered a breach of personal information in the last 12 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. | Does the applicant conduct background screens for prospective employees? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. | Is there a posted document retention/destruction policy in place? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. | Does the applicant centrally maintain regularly updated computer security measures on all computers, e.g. firewall, secured wireless connectivity, virus protection? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. | Are the applicant's employee, customer, and other physical records maintained in a separate and secure environment with limited access? |

In addition to the above, municipal applicants must compete the following section.

- | | | | |
|--------------------------|--------------------------|-----|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 6. | Is access to personal information restricted by job position? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. | Is the municipality responsible for collecting taxes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. | Is there an employee responsible for the security and privacy of information? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. | Does the municipality have a comprehensive Information Security and Privacy Policy? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. | Does the municipality provide regular security training/information to all people who have access to personally identifying information, whether in paper or electronic format? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. | Are all users issued unique IDs and passwords when connecting to or accessing the internal network? |

Completed by

Position

Date



AGENCY CUSTOMER ID: _____

UMBRELLA / EXCESS SECTION

DATE (MM/DD/YYYY)

IMPORTANT - If CLAIMS MADE is checked in the POLICY INFORMATION section below, this is an application for a claims-made policy.

AGENCY Public Risk Underwriters of Indiana, LLC		CARRIER EMC Insurance Companies	NAIC CODE
POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)	

POLICY INFORMATION

TRANSACTION TYPE				LIMIT OF LIABILITY		RETAINED LIMIT	
<input checked="" type="checkbox"/>	NEW	<input checked="" type="checkbox"/>	UMBRELLA	\$	EA OCC	\$	
<input type="checkbox"/>	RENEWAL	<input type="checkbox"/>	EXCESS				
		<input type="checkbox"/>	OCCURRENCE				
		<input type="checkbox"/>	CLAIMS MADE				
EXPIRING POL #:							FIRST DOLLAR DEFENSE (Y / N)

EMPLOYEE BENEFITS LIABILITY

LIMIT OF INSURANCE (Ea Employee) \$	AGGREGATE LIMIT FOR EBL \$	RETAINED LIMIT FOR EBL \$	RETROACTIVE DATE FOR EBL
NAME OF BENEFIT PROGRAM			

PRIMARY LOCATION & SUBSIDIARIES (ACORD 125)

#	NAME AND LOCATION OF PRIMARY AND ALL SUBSIDIARY COMPANIES (Describe Operations)	ANNUAL PAYROLL	ANN GROSS SALES	FOREIGN GROSS SALES	# EMPL
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				

UNDERLYING INSURANCE

LIST ALL LIABILITY / COMPENSATION POLICIES IN FORCE TO APPLY AS UNDERLYING INSURANCE						+/- RATING MOD
TYPE	CARRIER / POLICY NUMBER	POLICY EFF DATE	POLICY EXP DATE	LIMITS	ANNUAL RENEWAL PREMIUM	
AUTOMOBILE LIABILITY				CSL EA ACC \$	\$	
				BI EA ACC \$	\$	
				BI EA PER \$	\$	
				PD EA ACC \$	\$	
GENERAL LIABILITY POLICY TYPE <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE				EACH OCCURRENCE \$	PREM / OPS	
				GENERAL AGGR \$	\$	
				PROD & COMP OPS AGGREGATE \$	PRODUCTS	
				PERSONAL & ADV INJURY \$	\$	
				DAMAGE TO RENTED PREMISES \$	OTHER	
				MEDICAL EXPENSE \$	\$	
EMPLOYERS LIABILITY				EACH ACCIDENT \$	\$	
				DISEASE EACH EMPLOYEE \$		
				DISEASE POLICY LIMIT \$		
					\$	
					\$	

UNDERLYING INSURANCE (continued)

UNDERLYING GENERAL LIABILITY INFORMATION (Explain all "YES" responses)

1. ARE DEFENSE COSTS:	WITHIN AGGREGATE LIMITS?	A SEPARATE LIMIT?	UNLIMITED?
2. INDICATE THE EDITION DATE OF THE ISO FORM OR SIMILAR FILING FOR THE UNDERLYING COVERAGE:			
3. HAS ANY PRODUCT, WORK, ACCIDENT, OR LOCATION BEEN EXCLUDED, UNINSURED OR SELF INSURED FROM ANY PREVIOUS COVERAGE? (Y / N) <input type="checkbox"/>			
4. FOR CLAIMS MADE, INDICATE RETROACTIVE DATE OF CURRENT UNDERLYING POLICY:			
5. FOR CLAIMS MADE, INDICATE ENTRY DATE INTO UNINTERRUPTED CLAIMS MADE COVERAGE:			
6. FOR CLAIMS MADE, WAS "TAIL" COVERAGE PURCHASED FOR ANY PREVIOUS PRIMARY OR EXCESS POLICY? (Y / N) <input type="checkbox"/> EFF. DATE: _____			

CHECK ALL COVERAGES IN UNDERLYING POLICIES. ALSO CHECK IF ANY EXPOSURES ARE PRESENT FOR EACH COVERAGE. PROVIDE AN EXPLANATION. EXPLAIN IF DIFFERENT LIMITS, EXTENSIONS, OR EXCLUSIONS. EXPLAIN ANY SPECIAL COVERAGES BEYOND STANDARD FORMS. **EXPLAIN ALL EXPOSURES.**

CHECK IF APPROPRIATE	COVERAGE	EXPOSURE	COVERAGE	EXPOSURE
<input type="checkbox"/> ANY AUTO (SYMBOL 1)	CARE, CUSTODY, CONTROL		PROFESSIONAL LIABILITY (E&O)	
<input type="checkbox"/> CGL - CLAIMS MADE	EMPLOYEE BENEFIT LIABILITY		VENDORS LIABILITY	
<input type="checkbox"/> CGL - OCCURRENCE	FOREIGN LIABILITY / TRAVEL		WATERCRAFT LIABILITY	
<input type="checkbox"/> COVERAGE	EXPOSURE			
<input type="checkbox"/> AIRCRAFT LIABILITY	GARAGEKEEPERS LIABILITY			
<input type="checkbox"/> AIRCRAFT PASSENGER LIABILITY	INCIDENTAL MEDICAL MALPRACTICE			
<input type="checkbox"/> ADDITIONAL INTERESTS	LIQUOR LIABILITY			
	POLLUTION LIABILITY			

UNDERLYING INSURANCE COVERAGE INFORMATION (INCLUDE ALL RESTRICTIONS; e.g. LASER ENDORSEMENTS, DISCRIMINATION, SUBROGATION WAIVERS, OR EXTENSIONS OF COVERAGE) Attach ACORD 101, Additional Remarks Schedule, if more space is required.

PREVIOUS EXPERIENCE: (GIVE DETAILS OF ALL LIABILITY CLAIMS EXCEEDING \$10,000 OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS, DURING THE PAST FIVE (5) YEARS, WHETHER INSURED OR NOT. SPECIFY DATE, COVERAGE, DESCRIPTION, AMOUNT PAID, AMOUNT OUTSTANDING) Attach ACORD 101, Additional Remarks Schedule, if more space is required.

NO SUCH CLAIMS

CARE, CUSTODY, CONTROL

LOC	PROPERTY TYPE	VALUE	A*	B*	C*	D*	SQ FT OF BLDG OCC
	REAL						
	PERSONAL						

OCCUPANCY / DESCRIPTION OF PERSONAL PROPERTY

*APPLICANT: [A] IS HELD HARMLESS IN THE LEASE, [B] HAS A WAIVER OF SUBROGATION, [C] IS A NAMED INSURED IN THE FIRE POLICY, [D] OTHER (specify)

VEHICLES

TYPE	# OWNED	# NON-OWNED	# LEASED	PROPERTY HAULED	RADIUS (MILES)		
					LOCAL	INTER-MEDIATE	LONG DISTANCE
PRIVATE PASSENGER							
TRUCKS	LIGHT						
	MEDIUM						
	HEAVY						
	EX. HEAVY						
TRUCKS / TRACTORS	HEAVY						
	EX. HEAVY						
BUSES							

ADDITIONAL EXPOSURES

EXPLAIN ALL "YES" RESPONSES, PROVIDE OTHER INFORMATION REQUIRED	Y / N
ADVERTISERS LIABILITY	
1. MEDIA USED: ANNUAL COST: \$	
2. ARE SERVICES OF AN ADVERTISING AGENCY USED?	
3. ANY COVERAGE PROVIDED UNDER AGENCY'S POLICY?	
AIRCRAFT LIABILITY	
4. DOES APPLICANT OWN / LEASE / OPERATE AIRCRAFT?	
AUTO LIABILITY	
5. ARE EXPLOSIVES, CAUSTICS, FLAMMABLES OR OTHER DANGEROUS CARGO HAULED?	
6. ARE PASSENGERS CARRIED FOR A FEE?	
7. ANY UNITS NOT INSURED BY UNDERLYING POLICIES?	
8. ARE ANY VEHICLES LEASED OR RENTED TO OTHERS?	
9. ARE HIRED AND NON-OWNED COVERAGES PROVIDED?	
CONTRACTORS LIABILITY	
10. IS BRIDGE, DAM, OR MARINE WORK PERFORMED?	
11. DESCRIBE TYPICAL JOBS PERFORMED (Attach ACORD 101, Additional Remarks Schedule, if more space is required)	
12. DESCRIBE AGREEMENT (Attach ACORD 101, Additional Remarks Schedule, if more space is required)	
13. DOES APPLICANT OWN, RENT, OR OTHERWISE USE CRANES?	
14. DO SUBCONTRACTORS CARRY COVERAGES OR LIMITS LESS THAN APPLICANT?	
EMPLOYERS LIABILITY	
15. IS APPLICANT SELF-INSURED IN ANY STATE?	
16. SUBJECT TO: <input type="checkbox"/> JONES ACT <input type="checkbox"/> FELA <input type="checkbox"/> STOP GAP <input type="checkbox"/> OTHER:	
INCIDENTAL MALPRACTICE LIABILITY	
17. IS A HOSPITAL OR FIRST AID FACILITY MAINTAINED?	
18. ARE COVERAGES PROVIDED FOR DOCTORS / NURSES?	
19. INDICATE # OF DOCTORS: NURSES: BEDS:	

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

SIGNATURE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

IN FLORIDA, 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 MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN 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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

IF THE COMPANY TO WHICH I AM APPLYING OFFERS UNINSURED MOTORISTS (UM) AND/OR UNDERINSURED MOTORISTS (UIM) COVERAGE IN MY STATE:

UNINSURED MOTORISTS (UM) COVERAGE: \$ _____ * UNDERINSURED MOTORISTS (UIM) COVERAGE: \$ _____ *

* IF APPLICABLE IN YOUR STATE

APPLICABLE ONLY IN LOUISIANA, NEW HAMPSHIRE, VERMONT AND WISCONSIN

APPLICABLE ONLY IN LOUISIANA:

I ACKNOWLEDGE THAT UM COVERAGE HAS BEEN EXPLAINED TO ME, AND I HAVE BEEN OFFERED THE OPTION OF SELECTING UM LIMITS EQUAL TO MY LIABILITY LIMITS, UM LIMITS LOWER THAN MY LIABILITY LIMITS, OR TO REJECT UM COVERAGE ENTIRELY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION. (INITIALS) OR 2. I REJECT UM COVERAGE IN ITS ENTIRETY. (INITIALS)

APPLICABLE ONLY IN NEW HAMPSHIRE:

I ACKNOWLEDGE THAT UM COVERAGE HAS BEEN EXPLAINED TO ME, AND I HAVE BEEN OFFERED THE OPTION OF SELECTING UM LIMITS EQUAL TO MY LIABILITY LIMITS OR TO REJECT UM COVERAGE ENTIRELY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION. (INITIALS) OR 2. I REJECT UM COVERAGE IN ITS ENTIRETY. (INITIALS)

APPLICABLE ONLY IN VERMONT:

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED UM COVERAGE EQUAL TO MY LIABILITY LIMITS. I HAVE SELECTED THE LIMITS INDICATED IN THIS APPLICATION.

APPLICABLE ONLY IN WISCONSIN:

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED UNINSURED MOTORIST (UM) COVERAGE AND UNDERINSURED MOTORIST (UIM) COVERAGE.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION. (INITIALS) OR 2. I REJECT UM COVERAGE IN ITS ENTIRETY. (INITIALS)
3. I SELECT UIM LIMITS INDICATED IN THIS APPLICATION. (INITIALS) OR 4. I REJECT UIM COVERAGE IN ITS ENTIRETY. (INITIALS)

IMPORTANT - THE STATEMENTS (ANSWERS) GIVEN ABOVE ARE TRUE AND ACCURATE. THE APPLICANT HAS NOT WILLFULLY CONCEALED OR MISREPRESENTED ANY MATERIAL FACT OR CIRCUMSTANCE CONCERNING THIS APPLICATION. THIS APPLICATION DOES NOT CONSTITUTE A BINDER.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER

DAY CARE/EARLY LEARNING/LATCH KEY QUESTIONNAIRE

Date

Producer Public Risk Underwriters of Indiana, LLC P.O. Box 1247 Kokomo, IN 46903-1247		Name and Mailing Address: 		
Code	Subcode	Website Address		Policy/Account Number
		Effective Date	Expiration Date	

Yes No

1. Location of facility: _____
2. Is this building designed for this occupancy?
3. Type of program? _____
4. Licensed?
5. Hours of operation: _____
6. Days of the week: _____
7. Maximum number of children for which center is licensed: _____
8. Does the center provide care for physically or mentally handicapped children? If yes, please describe:

9. Number of licensed staff members: _____
10. Maximum child/adult ratio: _____
11. Do hiring practices include checking of personal references and police records?
12. Is any member of the staff under investigation for, or does any person have a previous record of child abuse or neglect?
13. Describe the following:
 Playground equipment:

14. Is the outdoor play area fenced?
15. Field trips (describe nature of trips, vehicles used and the source from which vehicles are procured, drivers):

16. Are written procedures in place for:
 - Emergency dismissals?
 - Child check out for other than legal guardian?
 - Medication distribution?
 - Discipline, including corporal punishment?

Completed By _____

Position _____

Date _____

SWIMMING POOL/WATERSLIDE QUESTIONNAIRE

Date _____

Producer Public Risk Underwriters of Indiana, LLC P.O. Box 1247 Kokomo, IN 46903-1247		Name and Mailing Address:		
Code	Subcode	Website Address:	Effective Date	Expiration Date
		Policy/Account Number:		

Rating information: Receipts _____ Pool located: Indoors Outdoors

If pool is located indoors, what floor of building? _____ What is located below the pool area? _____

Pool is: Public Private What is the size of the pool? _____

Yes No

- Is the pool/hot tub/spa in compliance with Virginia Graeme Baker Pool and Safety Act?
- Is there a Hot tub , spa, or sauna on premises?
If yes, how is the water temperature controlled? _____
- Is water clear and bottom visible?
- Are depth markings visible in and out of the water? Depth: Maximum _____ Minimum _____
- Is there a non-skid surface around the pool?
- Do diving boards, platforms, starting blocks, ladders and steps have slip resistant surfaces?
Number of springboards? _____ Height of all diving boards? _____
Depth of water beneath? _____
- Are "No Diving" signs posted where the depth is less than 5 feet?
- Is mouth of drain screened to prevent any part of person being drawn in?
- Children allowed in pool? What is minimum age requirement? _____
- Children's section roped off?
- Are there attendants or lifeguards on duty at all times pool is open?
- Are attendants/Lifeguards certified in First Aid/CPR?
- First Aid equipment provided?
- Is pool equipped with life rings and shepherd's hook?
- Are safety rules posted where everyone can read them?
- After dark hours operation? If yes, please explain: _____
- Any underwater lights?
- Showers provided?
- Are eating, smoking, drinking, glass container permitted in pool area?
- Is the pool equipped with an automatic ph/chlorine monitor and feeder?
- Are written maintenance records maintained?
- Is there fencing completely around the pool with a self closing, self latching gate? Height of fencing? _____
- Is there a water slide? *If yes, also complete page 2.*

Where are chemicals used for the pool stored? _____

If in a separate room, how is access gained? _____

Who tests the water in the pool? _____

What precautions are taken to prevent pollution of water?

Please describe how unauthorized use prevented when pool is not in use or being drained?

WATERSLIDE(S)

1. Please describe where the water slide(s) is/are:

2. Please indicate whether each of the following apply to the water slide(s) on your premises. Explain all "no" responses in the area provided below:

Yes No

- Installed in compliance with Consumer Product Safety Commission and state regulations
- Supervised by two lifeguards – one at top, one at bottom
- Sliding is limited to feet-first only, all other is prohibited
- Only one person at a time is permitted on the slide
- Before being permitted on slide, all swimmers are required to demonstrate the ability to swim across a pool.
- Pool area where sliders enter the water is roped off and free of other swimmers.
- Ladder steps are slip-resistant
- Safety rules are posted where everyone can read them.
- Lifeguards/attendants are certified in first aid/CPR.
- First aid equipment is provided

Explanations for "no" responses

3. What is the height of each water slide? _____

4. How deep is the water beneath the slide(s)? _____

5. What is the minimum age permitted to use the slide? _____

Completed By

Position

Date

SPECIAL EVENT QUESTIONNAIRE

Date

Producer Public Risk Underwriters of Indiana, LLC	Name and Mailing Address:		
Code Subcode	Website Address		
	Effective Date	Expiration Date	Policy/Account Number

1. Name of event: _____
2. Location of event and ownership of premises: _____
3. Description of activities to be covered: (Include a detailed schedule of all activities. Include a brochure or website if available.)

4. Dates/duration of the event: _____
5. Estimated receipts: \$ _____
6. Estimated daily attendance: _____

7. Does the event include any of the following:

a. Mechanical or amusement rides or inflatable games?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
b. Alcohol sold or available? If yes, complete CG8037.1 Liquor Liability Application.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
c. Fireworks?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
d. Food, craft or other vendors?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Explain any yes responses:

8. Describe insured's responsibility for event (i.e., insured provides premises, provides funds, provides personnel, etc.):

9. List each sponsor/co-sponsor and their respective responsibilities for each event or activity:

<u>Sponsor/Co-Sponsor</u>	<u>Responsibility</u>

10. For those activities sponsored by someone other than the insured:
 - a. Is there an agreement in place? Yes No
 - b. Does the agreement require the sponsoring entity to hold the insured harmless and provide additional insured status to the insured? Yes No
 - c. Is a certificate of insurance obtained naming the insured as an additional insured? Yes No

11. Additional underwriting information:

a. Describe the protection in place for spectators.

b. Has similar insurance been purchased in the past? If yes, provide name of previous carrier. Yes No

c. Have any losses incurred during the last 3 years with this event? Yes No

If yes, provide claim details (date, description and amount of settlement).

*For those events that involve vehicular racing contests, demolition derbies, mechanical rides, or fireworks, contact EMC Underwriters LLC at 1-800-437-6005 to request coverage.

Remarks:

Completed by	Position	Date
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CLUB, ORGANIZATION OR ASSOCIATION QUESTIONNAIRE

To Be Completed For EACH Club Organization Or Association

Date

Producer Public Risk Underwriters of Indiana, LLC P.O. Box 1247 Kokomo, IN 46903-1247		Name and Mailing Address:		
Code	Subcode	Website Address:	Effective Date	Expiration Date
		Policy/Account Number:		

GENERAL INFORMATION

- Name of club, organization or association: _____
 - Number of years in existence: _____
 - Legal status of entity (corp., unincorp. assn., other): _____
 - Purpose of entity:
 - Type of fund raising activities conducted in most recent three years:
- If event includes sales, describe products sold.

ADDITIONAL INFORMATION

Yes No

1. Sponsor any events?
 If yes, provide details:
 List items sold by entity:
2. Do members perform crowd control at any school or other event?
 If yes, explain:
3. Is there any sponsorship of "hazardous events" (i.e. fireworks, tractor pulls, greased pig, donkey basketball or baseball, aircraft exposures or the like)?
 If yes, explain:
4. Are alcoholic beverages furnished, served or sold during any activity or meeting? If yes, provide details; including name of carrier and limits of insurance:

Thank you for your cooperation and assistance.

Completed By _____

Position _____

Date _____

SCHOOL SECURITY QUESTIONNAIRE

Date

Producer Public Risk Underwriters of Indiana, LLC P.O. Box 1247 Kokomo, IN 46903-1247		Name and Mailing Address:		
Code	Subcode	Website Address Effective Date		Expiration Date
		Policy/Account Number		

Yes No

- 1. Are the insured premises patrolled with security personnel?
- 2. Are the security personnel employees of the school?
- 3. Are the security personnel employed by an outside service?
- 4. Do you use both an outside service and school employees as security personnel?
- 5. Are teachers or other non-security personnel employees permitted to carry a weapon inside school buildings?

NOTE: If provided by an outside security service, a Certificate of Insurance must be provided showing that the security service has liability coverage at limits equal to or higher than that provided for the school, and that the school is named as Additional Insured on the liability coverage written for the security service. Also provide a copy of the contract with that security service.

6. How many security personnel are there? _____ Number armed? _____

7. How many of the security personnel are regularly employed as police officers? _____

- 8. Are there written guidelines for regularly employed police officers to secure authorization to "moonlight"?

When security services are provided by employees of the school, also, complete the following information:

- 1. Are those who are armed licensed and trained in weapons use?
- 2. Are psychological tests required?
- 3. Are employees permitted to carry weapons 24 hours a day?
- 4. Does training required include instruction in security personnel's legal powers and restrictions, particularly regarding arrest, searches, and use of a weapon?
- 5. Has the school secured legal assistance regarding review of the state law or regulations concerning:
 - a. Insurance requirement for security personnel?
 - b. Licensing requirements for security personnel, in addition to weapon permits?
- 6. Is there any working system for interchange of information and cooperation between the local Law Enforcement and the school security personnel? If yes, please describe.

7. What responsibilities will these employees have?

8. Who will supervise these individuals?

9. What level of training and experience in security does the supervisor have?

10. What prior training and experience are required of applicants?

11. What other screening procedures are included in your hiring practices?

Completed By

Position

Date