



STATEWIDE INSURANCE FUND

A JOINT INSURANCE FUND SERVING NEW JERSEY'S COMMUNITIES SINCE 1994

ONE SYLVAN WAY

PARSIPPANY, NJ 07054

862-260-2050

FAX 862-260-2058

New Business Application Process

Thank you for inquiring about obtaining a quote from Statewide Insurance Fund. Attached are the applications that should be submitted. Along with the applications, please provide 5 years of loss runs, the latest municipal budget data sheets, and the most recent financial statement.

Property including Auto Physical Damage

Attached is the blank Statement of Values and any applicable schedules in an excel format (please view all tabs at the bottom of the excel document). **Click on the paper clip along the left pane of the forms for the attachments.**

Please enter the information accordingly and **e-mail** them back to maleuthe@sifnj.com. Please do not send your agency management schedules, as they will be returned. The Office of the Administrator's staff does not have the authority to transfer your agency management schedule to the Fund schedule; it must be done by the risk management consultant or member.

Please note the following:

Statement of Values

1. In addition to the e-mail copy, please forward the hard copy with the applicable signature to our office (original is not required).
2. Our property carrier does require the information requested on the SOV form.
3. If no street # is listed at a location, please obtain if available.

Auto Schedule

1. If a "value" is not provided, we will only provide liability coverage.
2. Please provide the entire VIN.
3. With respects to emergency response vehicles *only* (fire trucks, ambulance - no police vehicles), please provide the current replacement cost of these vehicles to ensure that the entity will receive the maximum financial benefit in the event of a total loss. (Members can obtain a cost estimated replace cost from the manufacturer).



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Inland Marine Schedules

1. Fine Arts must be scheduled and value(s) stated. Blanket limits are acceptable for the EDP, and Equipment schedules.

Driver's List

1. Please update to include any employee authorized to drive an entity owned vehicle.

Auto and General Liability

Attached is the application. Please remember to complete the terrorism questionnaire and the dam questionnaire, if applicable. Please remember to include the entity's most recent budget.

Crime

Please be sure to enter the total number of locations where the entity could suffer a financial loss and the number of employees who handle funds on a regular basis.

Cyber Liability

Please be sure to enter the total number of credit card transactions processed and PII records. PII records are names and address ALONG with other data such as social security number, account numbers, passwords, PIN numbers, credit or debit card numbers, or Nonpublic Personal Information as defined by HIPAA. It is anticipated that most entities capture PII for their employees, rather than the public.

Law Enforcement Liability/Public Officials/Employment Practices Liability

Please note that the EPLI application requires the signature of the Human Resources Manager and Chief of Police/Sheriff. If the entity does not have a HRM, the Business Administrator/Clerk/Town Manager may sign the application. The Chief of Police signature is required in light of the increased EPLI claims occurring throughout the country in police departments.

Pollution Liability

Please forward the balance sheet and statement of operations pages of the most recent Financial Statement/Audit. Please note that we will require an original signature on this application. It can be forwarded after the applications are emailed to our office.



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Workers Compensation

An Acord application is acceptable for the Worker's Compensation coverage. Please be sure to provide payroll, employee count data and the employee census. In addition, please complete the Public Entity Supplemental Application attached.

Please feel free to contact our office if you have any questions. You can reach Caroline Conboy at 862-260-2055 or via email at cconboy@sifnj.com or MaryAnn Leuthe at 862-260-2065, email maleuthe@sifnj.com.



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In addition to comprehensive coverage at a competitive cost, membership in

STATEWIDE INSURANCE FUND includes the following services:

Managed Care Services for workers' compensation claims

- Toll-free number for reporting of injuries – 24 hours a day / 7 days a week
- Immediate referral of the patient to the provider
- Telephonic and On-Site Case Management by experience registered nurses
- Coordinate Return-to-Work programs with providers and members

Claims Administration Services for all types of claims

- Claims adjusters dedicated to public entity claims adjusting only
- Defense Counsel specializing in Title 34 and 59
- Aggressive Investigation and Subrogation & Recovery Programs
- On-Site Training Seminars

Loss Control Services

- Safety Committee Coordination
- PEOSHA Compliance and Training
- Accident/Claim Handling Procedures
- Safety Manual Development
- On-Site Safety Seminars
- Web-base training for Preventing Sexual Harassment, Discrimination, and Wrongful Termination, Promoting Ethical Behavior and Child Safe Environments



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GENERAL INSTRUCTIONS FOR COMPLETING APPLICATIONS

1. Save the PDF Portfolio file to your computer

To save the PDF to your computer, select the "Save" icon and choose a location on your computer where you will be able to find it later. When you are ready to fill out the form, open the file and begin at step 2, below.

2. Entering data into a field

The hand icon must appear on the screen in order to enter data. Once the hand icon appears, click on the field in which you want to enter data and begin typing information. Tab to the next field. Be sure to press the enter key after you've entered data in the last field.

- **Radio buttons**

Any fields that contain a check box work like a toggle switch. Click on the check box and a check mark will appear when you click your mouse. In some cases, only one item in a group can be checked.

- **Calculated fields**

There are several fields on the forms that are calculated fields and data will automatically be filled in as the form is completed by the user.

3. Saving and printing

After completing the applications, save the file with the name of the entity. At this point, you can email the completed application to maleuthe@sifnj.com, and print the applications for the town official's signature. Please remember to submit the signature pages to Statewide. The original signature page is required for the pollution application only. All other signature pages can be emailed or faxed. (If your Adobe program only prints the form and doesn't print the information you enter, check the box "Print as Image" in the print dialogue box.)

4. Printing forms for manual completion

If you chose to submit handwritten forms, you can print out the blank applications and write the responses. Completed forms can be scanned and emailed to maleuthe@sifnj.com.

Statewide Insurance Fund
New Business Submission Checklist

Name of Entity:

- _____ General Information Application
- _____ Applicant's current adopted budget
- _____ Five years loss runs for all coverage valued within 120 days of proposal due date
- _____ Applicant's Latest approved annual audit

GENERAL LIABILITY

- _____ a. New Business Application (Remember to include the terrorism & dam questionnaire.)
- _____ b. Details on any losses in excess of \$25,000

AUTOMOBILE

- _____ a. Schedule of Vehicles (Remember to include cost new for physical damage coverage)
- _____ b. List of drivers (including d/o/b and lic numbers and confirmation all possess a current valid driver's license)
- _____ c. Details of any losses in excess of \$25,000

CRIME

- _____ Crime New Business Application

CYBER LIABILITY

- _____ Cyber New Business Application

POLLUTION LEGAL LIABILITY APPLICATION

- _____ Pollution New Business Application –must be signed prior to binding
If applicant has underground storage tanks - complete the UST application

PUBLIC OFFICIALS/EMPLOYMENT PRACTICES/LAW ENFORCEMENT LIABILITY COVERAGES

- _____ a. Professional Liability (EPLI - LEL -POL) Applications
Must be completed in full in order to quote. Must be signed prior to binding
- _____ b. Sewer/Water Utilities Questionnaire (Complete if entity has either or both exposures)
- _____ c. Constable Application (Contact our office for the application if needed)

WORKERS' COMPENSATION

- _____ a. Workers' Compensation Application (include # of employees by location)
- _____ b. Currently published experience modification, if applicable and available
- _____ c. Return to work policy if documented

UMBRELLA OR EXCESS LIABILITY

- _____ a. Umbrella/Excess Application
(Statewide Insurance Fund must write the underlying coverage.)

CYBER SECURITY

- _____ Cyber Application

Entity Name: _____ Quote Due Date: _____

RMC Information			
*Name of Agency / Brokerage:			
*Phone:		*Fax:	
*Address:			
*City:		*State:	*Zip:
*Agent/Broker Contact:	*Last Name:		*First Name:
*Office Phone:		*Office Phone Extension:	
*Cell Phone:		*Office Fax:	
*Email Address:			

Coverage	Check if Requested
Package Includes Auto & General Liability	
Crime	
Equipment Breakdown	
Cyber Liability	
Inland Marine	
Property and B&M	
Law Enforcement Liability	
Public Official Liability	
Employment Practices Liability	
Pollution	
Workers Comp	
Other	

Current Coverage Information (Must be Completed):

Coverage	Company Name	Expiration Date	Policy Limits	Premium	Deductible	Occurrence/ Claims Made	Retro Date
Property							
Earthquake							
Flood							
Inland Marine							
Crime							
General Liability							
Public Officials							
Law Enforcement							
Employment Practices							
Equipment Breakdown							
Automobile							
Excess/ Umbrella							



**Statewide Insurance Fund
New Business
Applicant Information Section**

A. APPLICANT INFORMATION

1. Legal Name of Public Entity: _____
2. Mailing Address: _____
City: _____ State: _____ Zip Code: _____ County: _____
3. Street Address (if different from above): _____
4. Phone: (_____) Fax: (_____) E-mail: _____
5. Population Served: _____ Seasonal Population: _____
6. Type of Public Entity:
 City/Town/Village/Township/Borough County Public School District
 Public Water Utility Public Sewer Utility Public Housing Authority
 Other (fully describe): _____

B. LOSS HISTORY (include insured and uninsured losses)

1. Five years' company loss runs, valued within the past six months, must be attached for all coverages requested. (Law Enforcement requires seven years' loss runs.) You can request this data from your risk manager or insurer.
2. Has any claim been made, or is any claim now pending against the public entity or any person in his/her capacity as an official or employee of the public entity? Yes No
If yes, give details including the nature of the complaint and the current status:

3. Does any official or employee have knowledge of any losses, claims, litigation or incident which may give rise to a claim? Yes No
If yes:
 - a. Give details including the nature of the incident and current status:

 - b. Confirm that the incident has been reported to current carrier Confirmed

C. GENERAL INFORMATION

1. Financial Information: Please provide actual amounts from all sources for the last three years:

Year	Revenue	Expenditures	Surplus (+)/Deficit (-) Provide an explanation for any significant surplus or deficit.	Accumulated Surplus

PLEASE ATTACH MOST CURRENT BUDGET.

2. Bond Information:
- a. What is the amount of outstanding bonds? _____ No Bonds Outstanding
 - b. What is your latest bond rating (Moody's or Standard & Poor's)? Rating: _____. No Current Rating
 - c. Has your public entity been in default on principal or interest on any bond? Yes No
If yes, explain:
3. Has any insurance been canceled, declined or non-renewed in the last five years? Yes No
If yes, explain:

D. RISK MANAGEMENT ANALYSIS

- 1. a. Does the entity have a safety/loss control program? Yes No
- b. Are there regular safety/loss control meetings conducted? Yes No
If yes, how often?
- c. Does the entity have an accident investigation program? Yes No
- d. Are all premises periodically inspected for safety? Yes No
Frequency?
- e. Is there a formal written program for preventative maintenance? Yes No
Frequency?
Buildings? Yes No
Equipment? Yes No
- 3. Does your entity have a disaster recovery plan in place? Yes No
- 4. Does your entity have a written procedure for terrorism preparedness? Yes No
- 5. Does your entity have someone charged with the responsibility of risk management?... Yes No
If yes, full-time part-time
If part-time, who performs this function?
- 6. Is the entity in compliance with the federally mandated Americans With Disabilities Act (ADA)? Yes No
- 7. Do you fund or supply personnel to any commission, board, authority, administrative department or other similar unit that is **independently operated** or **not directly operated by you**? Yes No
If yes, please list all those for which you desire coverage as additional insured(s) and provide a brief description of the relationship.
- 8. What is the largest city within a twenty-five (25) mile radius of your entity?
Population:

E. AUTHORIZED ENTITY REPRESENTATIVE

Your designee to report claims and receive notices:
Name:

Title:

F. ENTITY'S ATTESTATION AND FRAUD WARNING

FRAUD WARNING:

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.

Signature of Authorized Public Official

Title

Date



Statewide Insurance Fund

Public Entity Application Public Officials Liability (Claims Made) Section

Please attach a separate page for answers requiring explanations.

Legal Name of Public Entity: _____ Effective Date: _____

A. COVERAGE REQUESTED

1. Limit of Liability: Each Wrongful Act: \$ _____ Annual Aggregate: \$ _____
2. Retroactive date of expiring policy: _____
3. Deductible requested: \$ _____; or
SIR Requested: \$ _____
4. Land use planning and zoning coverage option? Yes No
5. Consent to Settle Coverage Option? Yes No

B. UNDERWRITING INFORMATION

1. Name of municipal attorney: _____ Name of municipal engineer: _____
2. Do you have a formal procedure in place for requests for variance to land development statutes? Yes No
If no, explain how this is handled: _____
3. Do you have a written master plan for development? Yes No
If yes, when was it adopted/revised? _____ (date)
If no, explain who is responsible for land development decisions: _____
4. What kind of formal training do your newly elected/appointed officials receive on governmental and employment issues? _____
5. Do you engage in any planning and zoning activities? Yes No
 - a. Do planning and zoning officials receive training regarding "open meeting" and hearing regulations? Yes No
 - b. Does your municipal attorney attend all meetings of the planning and zoning board? Yes No
6. Do you own or operate a landfill that has been designated as a hazardous waste or Superfund Site by the EPA? Yes No
7. Do you own or operate any nuclear power plants? Yes No
8. Has there been continuous claims made coverage for the past five (5) years? Yes No
If no, please explain: _____



Statewide Insurance Fund

9. Have any of the following occurred within the last five (5) years? (If any answer is yes, provide a detailed narrative on a separate sheet of paper.)
- a. Grand jury investigations or indictments of any public officials?..... Yes No
 - b. Disputes or claims alleging the wrongful granting or refusal to grant zoning changes, building permits or similar allowances? Yes No
 - c. Disputes or claims alleging wrongful approval of building designs or specifications?..... Yes No
 - d. Disputes or claims alleging civil rights violations in regards to poor environmental quality in a neighborhood? Yes No

C. UTILITIES/AUTHORITIES

1. Does the entity administer any of the following?
- a. Gas Utility* Yes No
If yes, complete supplementary questionnaire G.
 - b. Electric Utility* Yes No
If yes, complete supplementary questionnaire F.
 - c. Water Utility Yes No
If yes, complete supplementary questionnaire E.
 - d. Sewer Utility Yes No
If yes, complete supplementary questionnaire E.
 - e. Port Authority* Yes No
If yes, complete supplementary questionnaire N.
 - f. Transit Authority* Yes No
If yes, complete supplementary questionnaire N.
 - g. Airport Authority* Yes No
If yes, complete supplementary questionnaire N.
 - h. Housing Authority* Yes No
If yes, complete supplementary questionnaire H.
 - i. Schools* Yes No

(*Note: There is no coverage for loss that results from the conduct of duties by or for such utility or authority unless specifically added to the policy.)

Supplementary questionnaires are available on our website (www.swfund.com) or through the Fund Administrator or your Risk Manager.

Signature of Human Resources Manager/Employment Supervisor

Date



Statewide Insurance Fund

Public Entity Application Employment Practices Liability (Claims Made) Section

Please attach a separate page for answers requiring explanations.

Legal Name of Public Entity: _____ **Effective Date:** _____

A. COVERAGE REQUESTED

1. Limit of Liability: Each Wrongful Act: \$ _____ Annual Aggregate: \$ _____
2. Deductible Requested: \$ _____ or
 SIR Requested: \$ _____ With LAE Included in Retention Without LAE in Retention
 TPA Name, Address, Telephone, and Facsimile: _____
3. Extended Employment Practices Liability Endorsement Options:
 - a. Third Party Coverage Endorsement? Yes No
 - b. Supplementary Payments—Fair Labor Standards Act (FLSA)? Yes No
 - c. Supplementary Payments—Immigration Reform and Control Act of 1986 (IRCA)? Yes No

B. EMPLOYEE INFORMATION

1. Number of Employees:
 Include any elected or appointed officials in the employee counts.

	Full-time	Part-time	Seasonal	Volunteers
No. of Employees				

 - a. How many of the employees above are:
 - (1) School employees? _____
 - (2) Law enforcement employees (including clerical personnel)? _____
 - (3) Paid fire department employees? _____
 - (4) Volunteer fire department employees? _____
 Would you like terms to include the VFD/Paid Fire Department? Yes No
 If no, do they have separate coverage? Yes No
 - b. If seasonal employees are included, how many months during the year are they utilized? _____
 - c. What percentage of your workforce is unionized? _____%

2. Please provide:

	1 Year Prior	2 Years Prior
Total No. of employees:		
Total No. of employees terminated:		
Total No. of employees who left voluntarily:		

3. Have there been any layoffs of employees or reductions in force? Yes No
 If yes, please explain: _____

4. Do you have a formal reduction in-force policy? Yes No
 If yes, has this policy been reviewed by legal counsel? Yes No
5. Have you had a strike, slowdown or other employee disruption? Yes No
 If yes, please explain: _____
6. Are there any future layoffs or reductions in force planned?..... Yes No
 If yes, please explain: _____

C. POLICIES AND PROCEDURES

1. a. Do you have written guidelines, policies, or procedures that address the following?

	Written Procedures	Supervisor/ Manager Training in these areas?		Written Procedures	Supervisor/ Manager Training in these areas?
Americans With Disabilities Act	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Progressive Disciplinary Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discrimination	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Salary Administration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disputes/Grievances/ Handling Complaints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual Harassment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Hiring/ Interviews	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Termination	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance Reviews	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Time-Off Policies & FMLA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- b. Are the above policies and procedures contained in an employee handbook, or policies and procedures manual that is distributed to all employees? Yes No
 If yes, do you obtain written acknowledgements that employees have received the handbook/manual?..... Yes No
 If no, how are policies communicated to employees? _____
- c. What is the date of the last review by legal counsel? _____
- d. How often is the handbook reviewed by legal counsel? _____

2. Are grievance procedures communicated to all personnel upon hiring? Yes No

D. UNDERWRITING INFORMATION

1. Do you have a human resources department? Yes No
 a. If yes, name and title of individual in charge of human resources: _____
 b. If no, explain how the function is handled: _____
2. Do you have someone responsible for human resources/employment issues for your law enforcement personnel? Yes No
 a. If yes, name and title of individual in charge: _____
 b. If no, explain how the function is handled: _____
3. Are formal written job descriptions in place for all positions? Yes No
4. Do you have a formal, standardized employment application?..... Yes No
 a. If yes, has it been reviewed by legal counsel?..... Yes No
 b. If no application is used, how do you recruit new employees?

5. Do you use a psychological test to screen applicants, to promote employees or for the purpose of continuing employment?..... Yes No
 - a. If yes, is it administered to everyone?..... Yes No
 - b. If no, please explain: _____
 - c. Confirm results are reviewed by a person trained in this field? Confirmed Not Confirmed
6. Do you provide a written performance evaluation for all employees?..... Yes No
 - a. If yes, how often? _____
 - b. If no, explain how the employee evaluations are handled: _____
7. Do you require counsel from a human resources professional or a qualified labor relations attorney prior to termination of any employee? Yes No
8. Are you currently required to comply with any judicial or administrative agreement, order, decree or judgment relating to employment? Yes No

If yes:

 - a. attach a copy; and
 - b. explain the actions taken by the insured to bring into compliance: _____
9. Has there been continuous claims made coverage for the past five years?..... Yes No

If no, please explain: _____

Retroactive Date on current policy? _____

E. LOSS HISTORY

In the last five years:

1. Has any person, former employee, volunteer or job applicant made a claim or alleged unfair or improper treatment regarding hiring, remuneration, advancement or termination? Yes No
If yes, provide a detailed narrative.
2. Have you had any disputes involving integration, segregation, discrimination or violation of civil rights including sexual harassment or the Americans With Disabilities Act (ADA)? Yes No
If yes, provide a detailed narrative.
3. During the last five years, has any official or employee been the subject of claims by a non-employee for discrimination or sexual harassment? Yes No
If yes, provide a detailed narrative.
4. How many Equal Employment Opportunity Commission and State Human Rights Commission claims or complaints have been filed against the entity? _____
If any, attach a log of all such claims or complaints.

Signature of Human Resources Manager/Employment Supervisor

Signature of Police Chief/Sheriff

Date

Date



Statewide Insurance Fund

Public Entity Application Law Enforcement Liability Section (Standard Application)

Please attach a separate page for answers requiring explanations.

Legal Name of Public Entity: _____ Effective Date: _____

A. COVERAGE REQUESTED

1. Limit of Liability:
Each person: \$ _____ Each wrongful act: \$ _____ Annual aggregate: \$ _____
2. Coverage desired: Occurrence Claims Made Retroactive Date: _____
3. Deductible requested: \$ _____; or
SIR Requested: \$ _____ With LAE Included in Retention Without LAE in Retention
4. Consent to Settle Coverage Option?..... Yes No
5. Name of law enforcement department(s) or agency(ies) to be covered: _____

B. EMPLOYEE CLASSIFICATION

1. Provide number of employees for each type listed: *

Type of Employee	No.	Type of Employee	No.
Sheriff/Chief/Deputy Chief		Full time/jailers/matrons	
Personnel with rank of sergeant or higher		Part time/auxiliary/reserve officers	
Full-time personnel with regular street/road duties including detectives and investigators		Court security staff	
		Crossing guards	
Patrol and Attack Police Dogs (Please provide training certificates for dogs and handlers)		Civil process servers	
		Communication/dispatchers	
Jail administrator(s) Length of time in this position: _____		All other law enforcement agency employees not listed elsewhere in this table	

*Count each employee only once.

C. DEPARTMENT POLICIES AND PROCEDURES

1. Do you have written policies and procedures governing the following law enforcement operations?

Policy Description	Date of Last Revision
Use of deadly force..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Use of non-deadly force..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Use of force reports <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vehicle "hot pursuit" <input type="checkbox"/> Yes <input type="checkbox"/> No	
Motor vehicle stops and searches <input type="checkbox"/> Yes <input type="checkbox"/> No	
Firearms and less than lethal weapons <input type="checkbox"/> Yes <input type="checkbox"/> No	
Domestic violence..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Searches..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Custodial interrogation/detention..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service of warrant..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Transportation of prisoners..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Handling individuals who are intoxicated..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Handling individuals who are suffering from mental illness or impairment, need medical attention or suffering from emotional distress <input type="checkbox"/> Yes <input type="checkbox"/> No	
Communicable diseases..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical emergency plan (inmate treatment and transport policy, etc.)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

2. Are policies and procedures reviewed annually? Yes No

If yes, by whom: _____

3. Are policies and procedures distributed to all personnel? Yes No

4. Are policies and procedures reviewed periodically with personnel as part of formal training? Yes No

Is evidence of this periodic review stored in employee's personnel files? Yes No

5. Do you require use of force reports to be filed? Yes No

If yes, is there follow-up action? Yes No

How many reports were filed in the last twelve (12) months? _____

D. EDUCATION AND TRAINING

1. Indicate which of the following background checks are required prior to hiring:

- Criminal Investigation Motor Vehicle Records Psychological Testing
- Employment History Check Reference Check

2. Which of the above are conducted by an outside vendor? _____

a. If none, how is information gathered? _____

b. Are background checks retained? Yes No

If yes, how long? _____

3. Confirm that all armed street officers have received formal academy training and are in compliance with minimum state requirements:..... Confirmed Not Confirmed

4. Is formal training required before armed and assigned street duty? Yes No
 If no, verify officer is not armed or is accompanied by trained personnel: Confirmed

5. How often must officer re-qualify with any department issued weapon? _____

6. Explain what training part-time/reserve/auxiliary officers receive: _____
7. Minimum number of hours of annual in-service training: _____
8. Do you hire additional officers during seasonal population changes? Yes No N/A
 If yes, confirm they have received training in compliance with minimum state requirements:..... Confirmed Not Confirmed
9. Do all officers receive training in vehicular operations? Yes No
10. Are officers trained and qualified before using:
- | | | | |
|-----------------|--------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------|
| Baton/Asp? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Used | Control holds? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Used |
| Mace/Chemicals? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Used | Tasers? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Used |
11. Is all training documented on a training log? Yes No
 If yes, does documentation include the date of completion and re-certification? Yes No

E. EMERGENCY DISPATCH

1. Indicate which of the following emergency calls are handled by your police department:
 Emergency Dispatch Emergency Medical Fire Dispatch Other Municipalities
2. If above is applicable:
- a. How are calls documented and how long are the records maintained? _____
- b. What is the average number of calls received per month? _____
- c. Are all dispatchers trained and certified? Yes No
- d. If dispatching for other municipalities, provide population served: _____

F. GENERAL UNDERWRITING INFORMATION

1. Are you involved with any of the following:

Description	Is there a written contract?	Contract approved by legal counsel?
Contracting law enforcement to any other entity? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mutual aid or reciprocal agreements? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug task force or SWAT team? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, no. of officers assigned to Drug task force: _____ SWAT team: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Powers Agreement with any other municipalities? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe agreement: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there separate primary insurance for this agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No		

2. Do you require your agency to be named as an additional insured for any work contracted to others? Yes No
 Who provides liability insurance for those contract services? _____
3. a. Do you authorize employee "moonlighting"? Yes No
 b. Confirm no "moonlighting" in bars and taverns: Confirmed Not Confirmed
4. Are you accredited by any professional organizations? Yes No
 If yes, please provide certificates.
 What organization(s)? _____

5. Do you subscribe to LETN? Yes No
If yes, please provide certificate.
6. Has there been continuous claims made coverage for the past five years? Yes No
If no, please explain: _____

G. JAIL/HOLDING CELL/DETENTION CELL OPERATIONS

1. Do you operate (check all that apply): Jail Holding cell Detention cell No lockup facility
2. Are jail premises regularly inspected by:
- State Corrections officials? Yes No Not required Date of Inspection: _____
- Fire Inspectors? Yes No Not required Date of Inspection: _____
- Dept. of Health? Yes No Not required Date of Inspection: _____

**ATTACH A COPY OF LATEST INSPECTION REPORT or SUMMARY REPORT
and CORRECTIVE MEASURES TAKEN**

3. Facilities:
- Date constructed: _____ Date renovated: _____
- Number of cells: _____ State certified capacity: _____
- Average number of daily inmates: _____ Average length of stay: _____
- Number of high risk inmates: _____
- a. Are there smoke detectors in the jail area? Yes No
- b. Do you have walk-throughs? Yes No
At what intervals? _____
- c. Are random walk-throughs conducted? Yes No
- d. Are there audio/video systems? Yes No
If yes:
- (1) Cells designated for medical/suicide watch: Audio Video None
- (2) Booking area: Audio Video None
- (3) General common areas (walkways, etc.): Audio Video None
- (4) Sally port: Audio Video None

4. Have there been any suicides or attempted suicides in the last five years? Yes No
If yes, please explain and provide details of the corrective measures taken: _____

5. In the past three years have there been any of the following (check all that apply):
- Medical emergencies Sexual Assaults Assaults resulting in hospitalization
- Fatalities None
- If any have occurred, what corrective measures have been taken? _____

6. Are jailers required to maintain a jail log to document incidents, action taken, and identify witnesses? Yes No
If yes, how long is log retained? _____

7. Is the facility under a court order or consent decree? Yes No
If yes:
- a. Attach copy with any modifications; and
- b. Explain the actions taken by the insured to bring the facility into compliance.

8. Do you have a separate facility for juvenile detainees? Yes No

9. Does your facility house males and females? Yes No
 If yes, are males and females segregated? Yes No
10. Jailers:
- a. Number of jailers per shift: Day: _____ Evening: _____ Night: _____
- b. Are jailers on duty twenty-four (24) hours per day? Yes No
- c. Does dispatcher also act as jailer? Yes No
- d. Confirm that formal training is required prior to assignment for all jail officers and that formal training is in compliance with minimum state requirements Confirmed Not Confirmed
- e. Are policies and procedures reviewed periodically with jail personnel as part of formal training? Yes No
11. Do you have written policies governing jail/holding cell/detention cell operations? Yes No

Policy Description	Date of Last Revision
Intake screening of inmates/detainees <input type="checkbox"/> Yes <input type="checkbox"/> No	
Strip searches <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical treatment/sick call <input type="checkbox"/> Yes <input type="checkbox"/> No	
Storage and administration of medication <input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicide ID guidelines <input type="checkbox"/> Yes <input type="checkbox"/> No	
Use of deadly force <input type="checkbox"/> Yes <input type="checkbox"/> No	
Use of non-deadly force <input type="checkbox"/> Yes <input type="checkbox"/> No	
Use of force reports <input type="checkbox"/> Yes <input type="checkbox"/> No	
Handling individuals who are intoxicated <input type="checkbox"/> Yes <input type="checkbox"/> No	
Handling individuals who are suffering from mental illness or impairment, need medical attention or suffering from emotional distress <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are evacuation instructions posted through the facility <input type="checkbox"/> Yes <input type="checkbox"/> No	
Key control and security <input type="checkbox"/> Yes <input type="checkbox"/> No	
Restraints <input type="checkbox"/> Yes <input type="checkbox"/> No	
Visual observation of inmates/detainees <input type="checkbox"/> Yes <input type="checkbox"/> No	
Inmate transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	
Discipline procedures <input type="checkbox"/> Yes <input type="checkbox"/> No	
Handling persons with communicable diseases <input type="checkbox"/> Yes <input type="checkbox"/> No	
Grievance procedure for inmate complaints <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical emergency plan (inmate treatment and transport policy, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	

- a. Are policies and procedures distributed to all personnel? Yes No
- b. Are policies and procedures reviewed annually? Yes No
 If yes, by whom: _____
- c. Are policies and procedures reviewed periodically with personnel as part of formal training? Yes No
- d. Do you contract out medical services? Yes No
 (1) If no, what steps are taken to provide medical attention? _____
 (2) If yes, who provides service? _____
 (a) Do you require evidence of insurance? Yes No
 (b) Are you added as an additional insured? Yes No
- e. Do you require use of force reports to be filed? Yes No
 If yes, is there follow-up action? Yes No
 How many reports were filed in the last twelve (12) months? _____

Statewide Insurance Fund Professional Lines Supplemental

Public Entity Application Sewer/Water Utility Questionnaire E

Legal Name of Public Entity: _____ Effective Date: _____

A. SEWER UTILITY

1. Number of utility users: Industrial: _____ Commercial: _____ Residential: _____
2. Provide annual payroll (**less clerical**):
Plant operation: \$ _____ Construction: \$ _____ Cleaning: \$ _____
3. Provide number of sewer miles: Storm: _____ Sanitary: _____
4. What type of facility is operated? Treatment Plant Lift Stations Pumps
5. If treatment plant is operated:
 - a. Type of plant? Primary Secondary Tertiary
 - b. What regulatory agency is responsible for monitoring (DEC, EPA, Health Department)? _____

 - c. How often? _____
 - d. How is influent input monitored for toxic or hazardous waste? _____
 - e. How is residual by-product/sludge? _____
 - f. Has plant ever been fined or received a citation? Yes No
If "yes," explain: _____
 - g. Are any operations contracted? Yes No
If "yes," attach Certificate of Insurance and a copy of any hold harmless agreements.
6. How old is your system? _____ Year of last upgrade? _____
7. Is regular maintenance performed? Yes No
Are records kept for all repairs? Yes No

8. Have you had any past/present incidents of sewer back-up to residential or commercial property? Yes No
 If "yes," please explain (include dates, cause and corrective action taken): _____

B. WATER UTILITY

1. General Information

- a. Annual payroll (**less clerical**): \$ _____
- b. Number of gallons distributed annually: _____ Maximum annual capacity: _____
- c. Miles of pipe: _____ Total number of employees: _____
- d. Number of users: Residential: _____ Commercial: _____ Industrial: _____
- e. Number of: Water treatment plants: _____ Water tanks: _____ Water towers: _____
- f. Are all facilities fenced? Yes No
- g. Is water provided to neighboring entities? Yes No
 If "yes," describe and provide copies of contracts: _____

2. Source of water supply (lake, well, etc.): _____

- a. How old is your system? _____ Year of last upgrade? _____
- b. Composition of pipe?
- | | | |
|-----------------------------------------|-------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Lead _____% | <input type="checkbox"/> Cast iron _____% | <input type="checkbox"/> Asbestos _____% |
| <input type="checkbox"/> Plastic _____% | <input type="checkbox"/> Clay _____% | <input type="checkbox"/> Other _____% |

3. a. Has utility completed monitoring for lead in drinking water? Yes No

- b. Date completed: _____
- c. Test results:
- (1) Tap water monitoring: _____
- (2) Water quality monitoring: _____
- (3) Lead source water monitoring: _____
- d. If test results exceed the lead action level of 15 ppb, please comment on treatment techniques relating to (a) corrosion control, (b) source water, (c) public education, or (d) lead service line replacement as applicable:

4. How often is water tested? _____ By which regulatory agent? _____

5. Has system ever been cited or fined for non-compliance with required standards? Yes No
 If "yes," please provide details, copy of non-compliance notice(s) and action(s) taken to correct problem(s):

6. Does entity contract any part of water operations (construction, maintenance, inspection, etc.)? Yes No
 If "yes," provide certificates of insurance.

7. Does entity have a written disaster plan? Yes No

8. Is there a process in place for handling customer complaints or reported problems? Yes No



General Liability Exposure Information

Fund Year

Name of Entity:

Operation / Exposure	Do you have this exposure?	
Adoption/Foster Care Operations	Yes	No
Airport or Related Facility	Yes	No
Amusement Park	Yes	No
Architects	Yes	No
Arena / Auditorium / Convention Center	Yes	No
Athletic Participants	Yes	No
Blasting Operation	Yes	No
Blood Banks	Yes	No
Bridges over 300 ft	Yes	No
Campground	Yes	No
Cemetery	Yes	No
Chemical Spraying (pesticide / herbicide)	Yes	No
Dam / Levee / Dike	Yes	No
Day Care / Day Camp / Day Nursery	Yes	No
Dormitories	Yes	No
Engineers	Yes	No
EMT/Paramedic	Yes	No
Fire Department	Yes	No
Fireworks	Yes	No
Garbage / Refuse Collection	Yes	No
Golf Course	Yes	No
Habitational (Apartment, Dwelling)	Yes	No
Halfway House / Group Shelter / Group Home	Yes	No
Hospital / Nursing Home	Yes	No
Housing Authority / Project	Yes	No
Ice / Roller Rink	Yes	No
Independent Contractors	Yes	No
Industrial Development Commission	Yes	No
Jail / Detention Facility	Yes	No
Lake / Reservoir	Yes	No
Landfill / Dump / Incinerator / Recycling Center	Yes	No



General Liability Exposure Information

Fund Year

Name of Entity:

Operation / Exposure	Do you have this exposure?	
Law Enforcement	Yes	No
Library	Yes	No
Liquor Liability	Yes	No
Mechanical or Electrically Operated Amusement Device	Yes	No
Medical Clinic / Health Department	Yes	No
Medical Professionals (doctors, nurses, etc.)	Yes	No
Museum	Yes	No
Piers / Dock / Marina	Yes	No
Port Authority	Yes	No
Psychologist/Social Workers	Yes	No
Racing/Rodeo Exhibitions	Yes	No
Recreational Activities	Yes	No
Rifle / Shooting Range	Yes	No
School and Colleges	Yes	No
Skateboard Park / Facility	Yes	No
Ski Facility	Yes	No
Special Event (fairs, carnivals, parades, etc.)	Yes	No
Stadiums Greater than 10,000 seating Capacity	Yes	No
Streets / Roads / Highways / Bridges	Yes	No
Swimming Pool	Yes	No
Transit System	Yes	No
Utilities: Electric	Yes	No
Utilities: Gas	Yes	No
Utilities: Sewer	Yes	No
Utilities: Water	Yes	No
Watercraft / Boat	Yes	No
Waterslide	Yes	No
Zoo	Yes	No
Other Exposure	Yes	No



General Liability Exposure Information

Fund Year _____

Name of Entity:

Operation / Exposure	
<p>Please list all volunteer and paid fire department/district and volunteer rescue/first aid squads, that are included within the your general and auto liability coverage:</p>	
Rating Information Questionnaire	Amount
Population	
Employee Count	
Total Payroll	
Net Operating Expenditures	
Road Mileage - Paved	
Road Mileage - Unpaved	
Water Utility Payroll	
Electric Utility Payroll	
Police - Full Time	
Police - Part Time	
Police - Dispatchers	
Jail Area (Cells Only - in sq ft)	
# of cells	
Juvenile Detention Center - # of rooms	
Fire Department, EMTs, Paramedics & Nurses	
Annual Calls - Non-Emergency	
Annual Calls-Emergency	
Number of Professionals (Nurses)	
Number of Paid Firemen	
Number of Volunteer Firemen	
Number of Paid EMTs-Paramedics	
Number of Volunteer EMTs-Paramedics	



**General Liability
Exposure Information**

Fund Year _____

Name of Entity:

Lead Exposure Questionnaire		
Does the entity have any procedures for testing lead exp. levels in paint,dust,drinking water & soil at any bldgs built prior to 1980?	Yes	No
Please describe below.		
Have there been any adverse results arising out of the testing procedures described in D.1. above?	Yes	No
Please describe below.		
Please describe follow-up / abatement procedures.		



General Liability Exposure Information

Fund Year

Name of Entity:

Beaches/Lakes/Reservoirs/Swimming Pools		
a) Describe the approximate size of each beach/lake/reservoir/swimming pool area and indicate recreational facilities:		
b) Are there certified lifeguards on duty during scheduled swimming hours?	Yes	No
c) Are scheduled swimming hours posted?	Yes	No
d) Is the swimming pool area fenced?	Yes	No
e) Are there any slides?	Yes	No
f) Are there any diving boards?	Yes	No
g) Are pool regulations posted?	Yes	No
h) Are pool depths clearly marked?	Yes	No
i) Are employees trained in the use of chlorine?	Yes	No
j) Is chlorine in a locked facility?	Yes	No
k) If no swimming is allowed, are warning signs posted?	Yes	No

Bridges over 300 feet		
a) List all bridges over 300 feet in length.		
b) Are they maintained by the entity?	Yes	No
c) If not, by who?		
d) How often are the bridges inspected?		
d) Has any bridge not passed an inspection?	Yes	No
e) Are any bridges closed or condemned?	Yes	No
f) Are all bridges posted for size and weight limits?	Yes	No

PLEASE INCLUDE LATEST NATIONAL BRIDGE INSPECTION REPORT FOR ANY " k@8- \ t-k ' 7--u



General Liability Exposure Information

Fund Year

Name of Entity:

Emergency Services		
a) Does the applicant provide any specialized training to emergency responders?	Yes	No
b) If yes, please describe training, how often, who provides and who participates, is it mandatory)		
c) Is there an age requirement for emergency responder drivers? If so, age ____	Yes	No
d) Does applicant screen volunteers prior to acceptance (ie require MVR check, physical, etc.)	Yes	No
e) If yes, please describe requirements:		
f) Does fire department / rescue squad rent their facilit(ies)?	Yes	No
g) If yes, does any applicant volunteers or employees work the events?	Yes	No
h) Is there a written lease agreement executed for each rental?	Yes	No
i) Does the fire department - rescue squad have a liquor license?	Yes	No
j) If yes, does the fire department - rescue squad serve alcohol to members?	Yes	No
k) Does the fire department - rescue squad serve alcohol to anyone other than a member?	Yes	No



General Liability Exposure Information

Fund Year

Name of Entity:

Fireworks		
a) Does the applicant provide fireworks during the year?	Yes	No
b) If yes, how often?		
c) Does applicant contract a pyrotechnic vendor?	Yes	No
d) If yes, is a hold harmless favorable to the applicant executed?	Yes	No
e) Does applicant obtain COI from vendor?	Yes	No
f) Is applicant listed as an additional insured on vendor's COI?	Yes	No

Garbage Collection	
a) Number of residential customers:	
b) Number of commercial customers:	
c) Number of Industrial customers:	
d) Number of Rural customers:	

Independent Contractors		
a) Does the applicant use independent contractors?	Yes	No
b) If yes, do ALL have formal written agreements?	Yes	No
c) If yes, do ALL agreements include insurance requirements?	Yes	No

Landfill/Incinerator/Waste Reclamation Facilities		
a) List location, #acres, fenced?, age, supervised?, open/closed:		
b) Are any hazardous waste handled by any site?	Yes	No
c) Is the applicant aware of any prior activities, which involved hazardous waste?	Yes	No
d) Are there methane gas escape vents at all the landfills?	Yes	No
e) Does the applicant transport waste to sites that are on any Federal or State Superfund priority list?	Yes	No



General Liability Exposure Information

Fund Year

Name of Entity:

Parks/Playgrounds		
a) List names of parks and playgrounds?		
b) Are organized athletic activities offered?	Yes	No
c) Is all playground equipment in compliance with current regulations?	Yes	No
d) Are there any trampolines?	Yes	No

Special Events		
a) List annual special events:		
b) Are alcoholic beverages served at any of these events?	Yes	No
c) Are alcoholic beverages sold at any of these events?	Yes	No
d) If yes to b or c, is the applicant serving and/or selling?	Yes	No

Stadiums/Arenas/Auditoriums/Exhibition Halls		
a) Indicate Type:		
b) Indicate # of seats:		
c) Provide current year event schedule.		
d) Are any events sponsored by the applicant?	Yes	No
e) Is there a formal written agreement for all non-applicant sponsored events executed?	Yes	No
f) Does the agreement include insurance requirements?	Yes	No



General Liability Exposure Information

Fund Year

Name of Entity:

Streets and Roads		
a) Is there a prior notice ordinance in effect?	Yes	No
b) Is there a regular inspection program for streets, roads and sidewalks?	Yes	No
c) Does the applicant provide snow removal for other entities?	Yes	No

Transportation		
a) Does the entity provide any public or employee transportation (facilities and/or services)	Yes	No
b) If yes, please describe:		

Utilities - Sewer / Water (complete if you own or operate)

SEWER

a) Are the sewerage disposal plants maintained by the applicant?	Yes	No
b) Is the applicant responsible for constructing any sewer lines?	Yes	No
c) Is the applicant responsible for maintaining the sewer lines?	Yes	No
d) Number of miles of sewer lines:		
e) Age of the oldest sewer line:		

WATER

a) What is the source of the water supply?		
b) How is the water stored? (Open Reservoir, Open Surface Tanks, Elevated Tanks, Other)		
c) Please list the locations of the water treatment plants including year built and square footage:		
d) Is the applicant responsible for constructing any water lines?	Yes	No
e) Is the applicant responsible for maintaining any water lines?	Yes	No



General Liability Exposure Information

Fund Year

Name of Entity:

Wharves/Piers/Docks	
a) List all (location-construction-year built-how anchored-size)	
b) Who and how often are they inspected?	

The information provided in this application and all schedules are true and correct to the best of my knowledge.

Signature

Date

Print Name and Position



Name of Entity:

Terrorism Questionnaire	Do you have this	
Municipalities or Cities with population greater than 250,000?	Yes	No
Emergency Services located within a city with a population greater than 250,000?	Yes	No
Port/Transit authorities or operations (including any passenger rail)?	Yes	No
Water Utilities with > 250,000 customers)	Yes	No
Airports (including any flight schools)?	Yes	No
Bridges greater than 300 feet in length or located within a city with a population greater than 250,000?	Yes	No
Cruise Lines or Commuter Ferries	Yes	No
Convention/Exhibition Centers, Sports Arenas, Stadiums, & Concert Halls with fire code cap. or seating cap. greater than 10,000 persons?	Yes	No
Dams greater than 300 feet in length with downstream populations greater than 25,000?	Yes	No
Federal and/or State Government Buildings, and/or National Landmarks?	Yes	No
Hospitals with a bed count greater than 300, or located within a city with a population greater than 250,000?	Yes	No
Internet Companies (Internet Service Providers, Web Site Designers, & Consultants)	Yes	No
Buildings greater than 25 stories in height located within a city with a population greater than 250,000?	Yes	No
Public School Districts located within a city with a population greater than 250,000?	Yes	No
Tunnels greater than 300 feet in length?	Yes	No
Universities with resident student populations greater than 10,000, or located within a city with a population greater than 250,000?	Yes	No

FOR ANY QUESTION ANSWERED "YES", YOU ARE REQUIRED TO PROVIDE ADDITIONAL DETAILS & INFORMATION ABOUT YOUR ANSWER

Signature

Date

Print Name and Position



**Statewide Insurance Fund
SEXUAL ABUSE UNDERWRITING CHECKLIST**

Name of Entity:

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Is there a Sexual Abuse Prevention Program in place? | Yes | No |
| 2. Have written procedures encompassing rules, a code of conduct, & disciplinary measures been established for all staff and/or volunteers? | Yes | No |
| 3. Is training conducted for all employees & volunteers on the program & documentation maintained on attendees? | Yes | No |
| 4. Are procedures established to monitor implementation of the program? | Yes | No |
| 5. Are records & documentation maintained for all incidents or allegations reported? | Yes | No |
| 6. Do policies and procedures include a follow up mechanism on incidents or allegations reported including notification of proper authorities? | Yes | No |
| 7. Does the program include measures on handling staff or volunteers that are named in the report of the offense? | Yes | No |
| 8. Are there at least 3 reference checks performed on all employees & volunteers? | Yes | No |
| 9. Are background & criminal checks performed on all employees & Volunteers? | Yes | No |
| 10. Has legal counsel reviewed the policy and are there at least bi-annual reviews? | Yes | No |
| 11. Has Sexual Abuse Supplemental Application been completed? | Yes | No |
| 12. Have any allegations or incidents been reported or are known to have occurred? | Yes | No |

If **Yes**, provide complete details including the action taken on the staff members involved:

Additional comments:

Signature

Date

Print Name and Position

Statewide Insurance Fund

NAME OF ENTITY: _____

DAM/DIKE/LEVEE/RESERVOIR/SPILLWAY QUESTIONNAIRE

Please complete one questionnaire per dam/dike/levee/reservoir

To be completed for any barrier built to impound water that, if it broke, would release water in a flood like manner.

I. General Information

A. Structure Name: _____

B. Structure Location: _____

C. Type: Dam Dike Levee Reservoir Spillway

C. Year Built: _____

D. General Condition & Maintenance: Excellent Good Fair Poor

E. Built under the direction of: _____

F. Purpose(s): Agriculture _____ Power* _____
Flood control _____ Water Supply _____
Industrial _____ Other _____

In event of power failure, describe alternate source: _____

G. Hazard Code: Low Medium High

H. Safety: Safe Not Safe

I. Construction: _____

J. Dimensions: Height: _____
Base Width: _____
Top Width: _____

K. Name of Tributary Rivers: Upstream: _____
Downstream: _____

L. Normal Pond Measurements: # of acres: _____
Storage Capacity: _____

Is additional storage available in Flood State? _____

M. Water Leve Control Gates? _____ Other? _____

How are they operated? _____

By Whom? _____

II. Upstream Exposures

A. Are there any exposures to any of the following?

- Structures Railroads
Industrial Complex Agricultural Areas
Housing livestock
Recreation Areas crops
Bridges dwellings
Lower Dams barns/sheds

If yes, to any of above please specifically describe each:

**Statewide Insurance Fund
Dam Questionnaire**

NAME OF ENTITY: _____

III. Downstream Exposures

TYPE	DISTANCE	DESCRIPTION
Housing	_____	_____
Other Structure	_____	_____
Ind. Complex	_____	_____
Pumping Station	_____	_____
Lower Dams	_____	_____
Recreational Areas	_____	_____
Bridges	_____	_____
Highways	_____	_____
Railroads	_____	_____
Agricultural Areas	_____	_____

IV. Dam Inspection

How often? _____ By Whom? _____

Has risk been included in the National Program for Dam Inspection? Yes No

If yes, please attach a copy of the most recent inspection report and responses to recommendations.

If no, please attach a copy of the most recent independent inspection report.

V. Loss History

Please describe any losses or pending suits which have occurred involving the dam or reservoir; include the amount of damages paid and amounts in reserve:

VI. Please attach a copy of Emergency Procedures / Plan.

Signed/Title: _____

Date: _____



Automobile Liability Exposure Information

Name of Entity: _____

Automobile Liability Summary	# of Vehicles of this type
Private Passenger Cars (up to 10,000 lbs GVW) - Non Emergency	
Private Passenger Cars (up to 10,000 lbs GVW) - Emergency (e.g. Fire, Police)	
Light Trucks (up to 10,000 lbs GVW)	
Medium Weight Trucks (10,000 to 20,000 lbs GVW)	
Heavy Trucks (20,000 to 50,000 lbs GVW)	
Extra-Heavy Trucks (greater than 50,000 lbs GVW)	
Fire Trucks	
Ambulances	
Motorcycles	
Pick Up Trucks	
Truck - tractor	
Buses	
1-8 passenger	
9-20 passenger	
21-60 passenger	
61+ passenger	
Vans	
1-8 passenger	
9-14 passenger	
15+ passenger	
Total Vehicles	
Miscellaneous Powered Vehicles	
Please describe:	
Trailers, All Types	
Boats - power under 26 '	
Boats - power over 26 '	
Lists make/model - size (ft. & hp) and use:	

This Section Must Be Completed



Automobile Liability Exposure Information

Name of Entity:

h t@	
1. Fleet Management – Please advise of the following:	
Does the entity have a vehicle maintenance program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the entity have a formal accident investigation program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are all accidents reviewed internally and corrective action taken?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are drivers of 15-passenger vans specifically trained in the operation of these vehicles?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2. Motor Vehicle Reports (MVR)	
Does the entity order MVR's on all new drivers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often are MVR's updated?	<input type="checkbox"/> Annual <input type="checkbox"/> Other:
Do any drivers have a DUI arrest / conviction in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Employee Use of Vehicles	
Do any employees drive their own vehicles in the Entity's business?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list employees and occupations:	
If yes, advise of insurance requirements:	
Are employees allowed to take their vehicles home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is personal use permitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list employees and occupation:	

4. If law enforcement vehicles are included in the automobile schedule, do you have the following Policies and Procedures?		
Vehicular Pursuit	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Patrol Driving & Response	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Transportation of Prisoners	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Does the Entity provide any type of transportation services?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Indicate Type:	<input type="checkbox"/> Elderly Transportation <input type="checkbox"/> Other	

Signature

Date

Print Name and Position

**Statewide Insurance Fund
Crime Questionnaire**

Name of Entity: _____

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. Do you have a CPA Audit, at least annually, made in accordance with generally accepted auditing standards and so certified? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are bank accounts reconciled monthly by someone not authorized to deposit or withdraw therefrom? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Is Countersignature of checks required? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are incoming checks immediately stamped "For Deposit Only" to the credit of the applicant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Are all deposits made in the name of the applicant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Are securities subject to joint control by two or more responsible employees? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

7. IF A QUESTION IS ANSWERED "NO", EXPLAIN WHAT ALTERNATE CONTROL IS IN EFFECT

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 8. Total Number of locations. | _____ |
| 9. Number of locations where money or securities are handled. | _____ |
| 10. Number of employees who handle, have custody or maintain records of money, securities or other property; department and division heads; assistant department and division heads; and peace officers (including patrolmen) | _____ |
| 11. Total number of employees | _____ |
| 12. Has your operation experienced any of the losses in the past year, whether reimbursed or not? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, please provide details including: Date of Loss, Amount of Loss, Amount Recovered from Insurance, Amount of Loss Pending, Amount Recovered from other than Insurance, Type of Loss, and Corrective measures that have been implemented on a separate sheet.

Applicant Signature Date

Print Name and Title

Agent Signature Date

PUBLIC ENTITIES / EDUCATIONAL FACILITIES ENVIRONMENTAL INSURANCE APPLICATION

ADDENDUM I: Water Treatment Facilities / Wastewater Treatment Facilities

ENTITY: _____

**ONE ADDENDUM MUST BE COMPLETED FOR EACH LOCATION
LOCATIONS ARE NOT COVERED UNLESS SCHEDULED TO THE POLICY**

Entity: _____
 Physical Address of Storage Tanks Listed Below: _____
 City: _____ State: _____ Zip Code: _____
 EPA I.D. #: _____

1. What type of facility is this? (Check one)
 Water Treatment Facility Waste Water Treatment Facility
2. When was this facility designed and built? _____
3. What is the Total Population served by this facility? _____
4. When was this facility first permitted? _____
5. Is this site completely fenced and access restricted? YES NO
6. Are there any fuel storage tanks located at the site? YES NO
 If YES, please complete **Addendum G: Storage Tank Data Sheet.**

WATER TREATMENT

7. How many miles of pipelines is the entity responsible for? _____
8. Average amount of water treated per day (gallons)? _____
9. Maximum capacity treated water per day (gallons)? _____
10. Number of: _____ Water Tanks _____ Water Towers
11. Source of Water Supply for this facility: _____

WASTEWATER TREATMENT

12. How many miles of sewer lines is the entity responsible for? _____
13. Average amount of waste treated per day (gallons)? _____
14. Maximum capacity treated waste per day (gallons)? _____

15. Please complete the following for each permitted effluent discharge:

POLLUTANT	PERMITTED MAXIMUM AMOUNT	DAILY AVERAGE AMOUNT

16. Where and how is your effluent discharged? _____

17. What is done with the residual by-product/sludge? _____

RECLAIMED WATER

18. Does the facility sell or distribute any Reclaimed Water? YES NO
 If YES:
 - a. Average gallons of water reclaimed per day: _____
 - b. Percent Sold: _____ Percent reused by the entity: _____
19. Are signs posted in the area where reclaimed water is used? YES NO

20. On a separate page, describe the use and application of the reclaimed water.



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS		COMPANY:	
		UNDERWRITER:	
		APPLICANT NAME:	
		OFFICE PHONE:	MOBILE PHONE:
		MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)	
		YRS IN BUS:	
		SIC:	
		NAICS:	
		WEBSITE ADDRESS:	
PRODUCER NAME:		E-MAIL ADDRESS:	
CS REPRESENTATIVE NAME:		SOLE PROPRIETOR <input type="checkbox"/>	
OFFICE PHONE (A/C. No. Ext):		CORPORATION <input type="checkbox"/>	
MOBILE PHONE:		LLC <input type="checkbox"/>	
FAX (A/C. No.):		TRUST <input type="checkbox"/>	
E-MAIL ADDRESS:		PARTNERSHIP <input type="checkbox"/>	
		SUBCHAPTER "S" CORP <input type="checkbox"/>	
		JOINT VENTURE <input type="checkbox"/>	
		OTHER <input type="checkbox"/>	
CODE:	SUB CODE:	CREDIT BUREAU NAME:	ID NUMBER:
		FEDERAL EMPLOYER ID NUMBER	OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER
		NCCI RISK ID NUMBER	
AGENCY CUSTOMER ID:			

STATUS OF SUBMISSION**BILLING / AUDIT INFORMATION**

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN	PAYMENT PLAN	AUDIT
<input type="checkbox"/> BOUND (Give date and/or attach copy)		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL <input type="checkbox"/>	<input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> MONTHLY
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/>
			<input type="checkbox"/> QUARTERLY % DOWN:	<input type="checkbox"/> QUARTERLY

LOCATIONS

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING NON-PARTICIPATING	RETRO PLAN
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)	AMOUNT / % (N / A in WI)
	\$ EACH ACCIDENT		<input type="checkbox"/> MEDICAL	<input type="checkbox"/> U.S.L. & H.
	\$ DISEASE-POLICY LIMIT		<input type="checkbox"/> INDEMNITY	<input type="checkbox"/> VOLUNTARY COMP
	\$ DISEASE-EACH EMPLOYEE			<input type="checkbox"/> FOREIGN COV
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION			
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)				

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
\$	\$	\$

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION				
ACCTNG RECORD				
CLAIMS INFO				

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

PRIOR CARRIER INFORMATION / LOSS HISTORY

AGENCY CUSTOMER ID: _____

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS						LOSS RUN ATTACHED
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y/N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	
2. 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)	
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	
9. ANY GROUP TRANSPORTATION PROVIDED?	
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	
11. ANY SEASONAL EMPLOYEES?	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y/N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	
15. ARE ATHLETIC TEAMS SPONSORED?	
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	
17. ANY OTHER INSURANCE WITH THIS INSURER?	
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question)	
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	

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

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APPLICABLE IN TENNESSEE AND VERMONT: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

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 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.

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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ARCH WEXFORD

VEHICLE SUPPLEMENTAL APPLICATION

NAME OF APPLICANT: _____

NUMBER OF EMPLOYEE DRIVERS: _____

NUMBER OF OWNED OR LEASED VEHICLES:

PASSENGER CARS: _____ VANS/TRUCKS: _____ TRACTORS: _____ TRAILERS: _____

NUMBER OF OWNER/OPERATORS: _____

IS APPLICANT RESPONSIBLE FOR WORKERS COMPENSATION COVERAGE ON OWNER / OPERATOR? YES NO

IF "YES", WHAT PERCENTAGE OF THE PAYROLL REPRESENTS THESE DRIVERS? _____

IF NOT, ARE CERTIFICATES OF WORKERS COMPENSATION INSURANCE OBTAINED? _____

DOES APPLICANT PROVIDE ANY TRANSPORTATION OF EMPLOYEES TO OR FROM THE WORKPLACE? YES NO

IF "YES", DESCRIBE FREQUENCY OF TRIPS, MODE OF TRANSPORTATION AND NUMBER OF EMPLOYEES:

DESCRIBE APPLICANT'S USE OF TRUCKS: _____

TYPE OF GOODS HAULED: _____

IS THERE ANY TRANSPORTATION OF HAZARDOUS MATERIALS? YES NO

IF "YES", DESCRIBE: _____

WHAT IS THE AVERAGE RADIUS OF TRAVEL? _____

PRIMARY STATES: _____

FREQUENCY OF TRIPS: _____

NUMBER OF EMPLOYEES IN EACH UNIT: _____

WHAT IS THE MAXIMUM RADIUS OF TRAVEL? _____

PRIMARY STATES: _____

FREQUENCY OF TRIPS: _____

NUMBER OF EMPLOYEES IN EACH UNIT: _____

DOES APPLICANT HOLD INTRASTATE AND / OR INTERSTATE LICENSES TO HAUL FOR OTHERS? YES NO



DOES APPLICANT BACKHAUL GOODS FOR OTHERS? YES NO

IF "YES", GIVE FREQUENCY OF TRIPS: _____

TYPE OF GOODS MOST COMMONLY BACKHAULED: _____

DESCRIBE VEHICLE MAINTENANCE PROGRAM: _____

PROVIDE, IF AVAILABLE, ANY WRITTEN PROCEDURES ON DRIVER TRAINING, DOT CERTIFICATION, MVR CHECKS, DISCIPLINARY PROGRAMS, ETC.



Public/Educational Entity Pollution Liability Insurance Policy

Application

Instructions:

- Please type or print clearly.
- Answer **ALL** questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.
- Provide any supporting information on a separate sheet using the applicant's letterhead and reference the applicable question number.
- Check Yes or No answers.
- This form must be completed, dated and signed by an authorized representative of the applicant.

Required Attachments:

- Tank Inventory Lists (check here if not applicable)
- Locations Schedule

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy and any endorsement thereto. The policy provides liability coverage on a CLAIMS-MADE AND REPORTED basis, which covers only claims first made against an insured and reported to the Insurer, in writing, during the policy period. The policy also provides coverage for remediation costs on a DISCOVERED AND REPORTED basis, which covers only pollution conditions first discovered and reported to the Insurer, in writing, during the policy period.

1. Name of Applicant: _____

Principal Contact: _____ E-mail Address: _____

Principal Contact Regarding Mold, Asbestos and Lead Health & Safety Issues: _____

Mailing Address: _____

Telephone #: _____ Fax #: _____

2. Types of Exposures to be covered under this policy (check all that apply)

- Above Ground Storage Tanks
- Airports
- Bus Depots
- Educational Facilities
- Electric Utility
- Gas Utility
- Golf Courses
- Hazardous Waste Facilities
- Health Clinics
- Hospitals
- Housing Authorities
- Irrigation Districts
- Municipal Garages
- Landfills

- Nursing Homes/Assisted Living Communities
- Reclaimed Water Sales/Use
- Recycling Facilities (non-hazardous)
- Service Work (outside of covered locations)
- Sewage Districts
- Spraying Operation (weed/pesticide)
- Underground Storage Tanks
- Wastewater Treatment Facilities
- Water Districts
- Water Treatment Facilities

List other facility types or operations here (if applicable):

- 3. Population (Municipalities): _____
- 4. Enrollment (School Districts): _____
- 5. Desired effective date of coverage: 1/1
- 6. Limits of Liability and Self-Insured Retention requested:

Limits of Liability:	Self-Insured Retention:
Per Pollution Condition: \$ <u>1,000,000</u>	Per Pollution Condition: \$ <u>25,000</u>
Aggregate: \$ <u>3,000,000</u> per member	

- 7. Within the past five (5) years has the applicant or any other party to this insurance purchased this type of insurance coverage? YES NO
 - a. If "Yes" is indicated above, please provide detailed information regarding any such coverage and all available loss information as an attachment to this application. Retroactive Date: _____
- 8. Within the past five (5) years have any claims been made or legal actions (including any regulatory proceedings) been brought against the applicant or any other party to the proposed insurance? YES NO
- 9. Does the applicant or any other party to the proposed insurance have knowledge of any pollution conditions at any of the proposed covered locations? YES NO
- 10. Does the applicant or any other party to the proposed insurance have knowledge of Injury to people or damage to property during the last five (5) years on or at projects where the applicant performed covered operations? YES NO
- 11. Does the applicant or any other party to the proposed insurance have knowledge of any claims made or pollution conditions during the last five (5) years resulting from the transportation of the applicant's or any other party's waste, goods or products? YES NO
- 12. Does the applicant or any other party to the proposed insurance have knowledge of any claims made with respect to pollution conditions on, at, under or migrating from any disposal sites to which the applicant's or any other party's waste is currently being, or has historically been, taken for recycling or disposal? YES NO
- 13. At the time of signing this application, is the applicant or any other party to the

proposed insurance aware of any circumstances that may reasonably be expected to give rise to a claim against the applicant or any other party to the proposed insurance from the release of pollutants? YES NO

If "Yes" is indicated with respect to questions 8., 9., 10., 11., 12., and/or 13., above, please provide a detailed description of the claim or circumstance (indicate the alleged incident, location, date, type of injury, etc.). Also, please provide a summary of any steps that may have been taken to avoid or mitigate the possibility of a similar loss occurring in the future.

***IT IS UNDERSTOOD AND AGREED THAT IF ANY SUCH CLAIMS EXIST, OR ANY SUCH FACTS OR CIRCUMSTANCES EXIST WHICH COULD GIVE RISE TO A CLAIM, THEN THOSE CLAIMS AND ANY OTHER CLAIMS ARISING FROM SUCH FACTS OR CIRCUMSTANCES ARE EXCLUDED FROM THE PROPOSED INSURANCE UNLESS OTHERWISE AFFIRMATIVELY STATED IN THE POLICY.**

Supplemental Information for Storage Tank Coverage

If you are seeking coverage for pollution conditions emanating from storage tanks, please complete the following.

If you are not, please confirm that the items below are not applicable by checking here:

14. Are all of the storage tanks to be covered pursuant to this insurance (hereinafter Storage Tanks) compliant with all applicable federal, state and local laws and regulations? YES NO
- a. *If "No" is indicated above, please provide a written explanation of outstanding compliance issues as an attachment to this application.*
15. Are any of the Storage Tanks located within the State of Florida? YES NO
16. If the applicant answered "Yes" to Question 15., above, are any of the Florida-based Storage Tanks single-walled storage tanks (i.e., bare steel tanks, steel tanks with cathodic protection, STIP ¾ tanks or tanks operating under ACT 100), regardless of whether such single-walled storage tanks have any form of tank lining? YES NO
17. Have any other storage tanks been removed or closed-in-place in the locations where the Storage Tanks are currently situated? YES NO
- a. *If "Yes" is indicated above, please provide detailed information identifying the specific storage tanks to be covered pursuant to this insurance, which are situated at the common location.*
16. Will any of the Storage Tanks be removed, closed or upgraded within the next eighteen (18) months? YES NO

Supplemental Information for Lead-Based Paint and Asbestos Coverage

If you are seeking coverage for liability arising out of bodily injury or property damage resulting from exposure to Lead-Based Paint and/or Asbestos, complete the following.

If you are not, please confirm that the items below are not applicable by checking here:

17. Do any of the buildings located at the proposed covered locations contain lead-based paint? YES NO
18. If the applicant answered "Yes" to Question 17., above, does the applicant or any other relevant party to the proposed insurance have a lead-based paint management plan in place to address the lead-based paint? YES NO
- a. *If "Yes" is indicated above, please provide a copy of any such plan(s) as an attachment to this application.*
19. Do any of the buildings located at the proposed covered locations contain asbestos or asbestos-containing materials (ACM)? YES NO
20. If the applicant answered "Yes" to Question 19., above, does the applicant or any other relevant party to the proposed insurance have an asbestos management plan in place to address the asbestos? YES NO

a. If "Yes" is indicated above, please provide a copy of any such plan(s) as an attachment to this application.

21. Have any health concerns been raised, or any claims been made, with respect to the presence of lead-based paint, asbestos or asbestos containing materials at any of the buildings located at the proposed covered locations? YES NO

a. If "Yes" is indicated above, please provide detailed information regarding the health concerns and/or claims as an attachment to this application.

***IT IS UNDERSTOOD AND AGREED THAT IF ANY SUCH CLAIMS EXIST, OR ANY SUCH FACTS OR CIRCUMSTANCES EXIST WHICH COULD GIVE RISE TO A CLAIM, THEN THOSE CLAIMS AND ANY OTHER CLAIMS ARISING FROM SUCH FACTS OR CIRCUMSTANCES ARE EXCLUDED FROM THE PROPOSED INSURANCE UNLESS OTHERWISE AFFIRMATIVELY STATED IN THE POLICY.**

Supplemental Information for Mold, Fungi and/or Legionella Pneumophila Coverage

If you are seeking coverage for Mold, Fungi and/or Legionella Pneumophila, complete the following.

If you are not, please confirm that the items below are not applicable by checking here:

22. Do the applicant and any other parties to the proposed insurance perform due diligence with respect to mold and/or fungi when acquiring or leasing property such as in accordance with ASTM Standard E2418-06 "Standard Guide for Readily Observable Mold and Conditions Conducive to Mold in Commercial Buildings: Baseline Survey Process?" YES NO

a. If "Yes" is indicated above, please provide detailed information regarding the scope of that due diligence as an attachment to this application.

23. Have any of the buildings located at the proposed covered locations ever been identified as having mold, fungi, legionella pneumophila or similar bacteria-related problems? YES NO

a. If "Yes" is indicated above, please provide detailed information regarding the mold, fungi, legionella pneumophila or similar bacteria related problems as an attachment to this application.

24. Have any of the buildings located at the proposed covered locations experienced any water leaks or flooding within the past five (5) years? YES

a. If "Yes" is indicated above, please provide detailed information regarding the leaks or flooding as an attachment to this application.

25. Are any of the buildings situated at the proposed covered locations constructed using Exterior Insulation and Finish Systems (EFIS)? YES NO

a. If "Yes" is indicated above, please provide detailed information confirming the applicable locations as an attachment to this application.

26. Do the applicant and any other parties to the proposed insurance have any mold management and/or water intrusion plans in place? YES NO

a. If "Yes" is indicated above, please provide a copy of any such plan(s) as an attachment to this application.

27. Do employees or members of the applicant and any other parties to the proposed insurance receive any training regarding the handling of mold, fungi or legionella pneumophila or similar bacteria-related issues? YES NO

a. If "Yes" is indicated above, please provide detailed information regarding such training as an attachment to this application.

28. Have any health concerns been identified by, or any claims been made against, the applicant or any other parties to the proposed insurance with respect to mold, legionella pneumophila, similar bacteria-related issues or any other indoor air quality-related issues at buildings located on any of the proposed covered locations? YES NO

- a. If "Yes" is indicated above, please provide a brief description of the claim or circumstance (indicate the alleged incident, location, date, type of injury, etc.). Also, please provide a summary of any steps that may have been taken to avoid or mitigate the possibility of a similar loss occurring in the future.

***IT IS UNDERSTOOD AND AGREED THAT IF ANY SUCH CLAIMS EXIST, OR ANY SUCH FACTS OR CIRCUMSTANCES EXIST WHICH COULD GIVE RISE TO A CLAIM, THEN THOSE CLAIMS AND ANY OTHER CLAIMS ARISING FROM SUCH FACTS OR CIRCUMSTANCES ARE EXCLUDED FROM THE PROPOSED INSURANCE UNLESS OTHERWISE AFFIRMATIVELY STATED IN THE POLICY.**

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE INSURER THAT IT AND THE OTHER PARTIES TO THIS INSURANCE WILL STRICTLY FOLLOW ANY WATER INTRUSION, MOLD-RELATED, FUNGI-RELATED OR BACTERIA-RELATED OPERATION AND MAINTENANCE PROCEDURES OR PROTOCOLS, INCLUDING ANY WATER INTRUSION, MOLD-RELATED, FUNGI-RELATED OR BACTERIA-RELATED DUE DILIGENCE PROCEDURES OR PROTOCOLS FOR THE ACQUISITION, LEASE, OPERATION, MANAGEMENT OR MAINTENANCE OF ANY PROPERTIES, WHICH WERE PROVIDED TO THE INSURER PRIOR TO THE INCEPTION OF ANY COVERAGE APPLIED FOR HEREIN. THE APPLICANT ACKNOWLEDGES THAT THE INSURER'S AGREEMENT TO PROVIDE MOLD, FUNGI AND/OR LEGIONELLA PNEUMOPHILA COVERAGE AS PART OF THE COVERAGE APPLIED FOR PURSUANT TO THIS APPLICATION IS PREDICATED UPON THE APPLICANTS AGREEMENT TO PROVIDE THIS WARRANTY.

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE INSURER THAT IT AND THE OTHER PARTIES TO THIS INSURANCE WILL STRICTLY FOLLOW ANY LEAD-BASED PAINT OR ASBESTOS OPERATION AND MAINTENANCE PROCEDURES OR PROTOCOLS, WHICH WERE PROVIDED TO THE INSURER PRIOR TO THE INCEPTION OF ANY SUCH COVERAGE APPLIED FOR HEREIN. THE APPLICANT ACKNOWLEDGES THAT THE INSURER'S AGREEMENT TO PROVIDE LEAD-BASED PAINT AND/OR ASBESTOS COVERAGE AS PART OF THE COVERAGE APPLIED FOR PURSUANT TO THIS APPLICATION IS PREDICATED UPON THE APPLICANTS AGREEMENT TO PROVIDE THIS WARRANTY.

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE INSURER THAT ALL STATEMENTS MADE IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS THERETO, ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANTS ACCEPTANCE OF THE INSURERS QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

NOTICE TO APPLICANTS: 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.

NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA APPLICANTS: 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.

NOTICE TO COLORADO APPLICANTS: 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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 addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

NOTICE TO MINNESOTA APPLICANTS: A 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.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: 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 civil fines and criminal penalties.

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 violation.

NOTICE TO OHIO APPLICANTS: Any person who, with the intent to defraud or knowing that he 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: 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.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: 1) by submitting an application, or 2) by filing a claim containing a false statement as to any material fact may be violating state law.

NOTICE TO PENNSYLVANIA 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 subjects such person to criminal and civil penalties.

NOTICE TO TENNESSEE, VIRGINIA and WASHINGTON APPLICANTS: 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.

Signature of Authorized Applicant

Signature of Broker/Agent

Print Name

Print Name

Title

Date

Date

Signed by Licensed Resident Agent
(Where Required By Law)

PUBLIC ENTITIES / EDUCATIONAL FACILITIES ENVIRONMENTAL INSURANCE APPLICATION

ADDENDUM A: Airports and Former Military Bases / Property

ENTITY: _____

AIRPORTS

1. Does the Applicant own or operate any Airports? YES NO

If **YES**, please answer the following:

2. Name of Airport: _____

3. Address of Airport: _____

4. Average Number of Flights Daily: _____

5. Length of Longest Runway (feet): _____

6. If the Applicant owns or operates any fuel storage tanks, complete **Addendum G: Storage Tank Data Sheet**.

FORMER MILITARY BASES AND PROPERTY

7. Does the Applicant own or operate any covered location(s) that were formerly used by the Military? YES NO

If **YES**, which location and describe the history of the location.

8. When did the Applicant take custody of the location? _____

9. What is the current use of the location?

10. Are there any pollution conditions associated with the history of the location? YES NO If **YES**, please explain.

11. Who is responsible for the remediation of any pollutions conditions discovered at the location that were a result of its historical use?

12. Please provide information regarding any mandatory or voluntary environmental assessments or monitoring performed at the location:

PUBLIC ENTITIES / EDUCATIONAL FACILITIES ENVIRONMENTAL INSURANCE APPLICATION

ADDENDUM C: Gas and Electric Utilities

ENTITY: _____

GENERAL INFORMATION

Question	Gas	Electric	Other:
1. How many utilities does the Applicant operate?			
2. How many households are serviced?			

3. Describe the security systems that are in place for the utility.

4. Describe the emergency procedures and emergency shut-off systems for each location.

ELECTRIC UTILITIES

5. Address for each Electric Utility:

6. How is the electricity generated (steam, coal, gas, oil, etc)?

7. Describe fly ash disposal methods.

8. Does the fly ash disposal methods meet state and federal standards? YES NO If **NO**, please explain.

9. Do your emissions meet federal and state guidelines? YES NO If **NO**, please explain.

10. Do any of your transformers contain PCB? YES NO
If **YES**, how often are they inspected?

11. Have you received any Notices of Violations within the last five years? YES NO If **YES**, please explain.

12. Are there any fuel storage tanks located at the site? YES NO
If **YES**, please complete **Addendum G: Storage Tank Data Sheet**.

GAS UTILITIES

13. Address for each Gas Utility:

14. Please describe your natural gas distribution system.

15. How often are gas lines inspected?

16. Have you received any Notices of Violations within the last five years? YES NO If **YES**, please explain.

17. Are there any fuel storage tanks located at the site? YES NO
If **YES**, please complete **Addendum G: Storage Tank Data Sheet**.

PUBLIC ENTITIES / EDUCATIONAL FACILITIES ENVIRONMENTAL INSURANCE APPLICATION

ADDENDUM D: Landfills / Transfer Stations / Recycling Facilities

**ONE ADDENDUM MUST BE COMPLETED FOR EACH LOCATION
LOCATIONS ARE NOT COVERED UNLESS SCHEDULED TO THE POLICY**

Site Name:		
Physical Address:		
City:	State:	Zip Code:
State and/or EPA Identification#:		
1. What type of facility is this? (Check all that apply)		
<input type="checkbox"/> Active Landfill	<input type="checkbox"/> Transfer Station	
<input type="checkbox"/> Closed Landfill (additional information required)	<input type="checkbox"/> Material Recycling Facility	
2. When was this facility designed and built?		
3. When was this facility first permitted?		
4a. Who permits this facility?		
5a. Total Acreage:	5b. Disposal Acreage:	5c. Buffer Acreage:
6. Permitted maximum tons per day?		
7. Actual average tons per day?		
8. What is the estimated closure date of the facility?		
9. Have you received any Notices of Violations within the last five years? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , please explain		
10. Does the Applicant operate the facility? <input type="checkbox"/> YES <input type="checkbox"/> NO		
11. Describe the use of the Surrounding Properties.		
NORTH _____	EAST _____	
SOUTH _____	WEST _____	
LANDFILLS		
12. Is a composite liner in place? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , please describe liner material and thickness.		
13. Is a Leachate Collection System in place? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , how is the leachate stored and disposed of?		
14. Is a Groundwater Monitoring System in place? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , please provide the most recent groundwater monitoring reports.		
TRANSFER STATION / MATERIAL RECYCLING FACILITY		
15. Are there any systems for monitoring pollution conditions at the facility? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , please explain.		
16. Is the facility located at an active or closed landfill? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , please explain.		
17. List of Goods recycled:		

PUBLIC ENTITIES / EDUCATIONAL FACILITIES ENVIRONMENTAL INSURANCE APPLICATION

ADDENDUM E: Recreational Facilities / Medical Facilities

ENTITY: _____

RECREATIONAL FACILITIES

1. How many parks are owned by the Applicant? _____
 Total Acreage: _____
2. How many playgrounds do you have where the equipment is constructed of treated lumber? _____
3. How many playgrounds use recycled rubber chips as a base? _____
4. How many swimming pools does the Applicant maintain? _____
 What type of chemical treatment system is used? _____
5. How many ponds or lakes does the Applicant maintain? _____
 How many are used for recreational swimming? _____
6. How many golf courses does the Applicant maintain? _____
 Please describe chemical use and storage. _____
7. Does the Applicant own any Arenas or Stadiums? YES NO
 If YES, what is the total capacity? _____

MEDICAL FACILITIES

Question	Hospitals	Medical Clinics	Nursing Home/Assisted L
Total Number of Facilities?			
Number of Beds?			
Number of patients per year?			
Number of on-site laboratories?			
Number of employees?			
Number of on-site incinerators?			

Are there any fuel storage tanks located at the site? YES NO
 If YES, please complete **Addendum G: Storage Tank Data Sheet.**

PUBLIC ENTITIES / EDUCATIONAL FACILITIES ENVIRONMENTAL INSURANCE APPLICATION

ADDENDUM F: Chemical Storage / Spraying Operations / Service Work

ENTITY: _____

CHEMICAL STORAGE

1. Are all chemical storage facilities secured? YES NO

2. Are written emergency spill procedures provided to employees who handle chemicals? YES NO

CHEMICAL SPRAYING OPERATIONS

3. Does the Applicant perform any spraying operations? YES NO

4. Does the Applicant perform any aerial spraying operations? YES NO

Please Note: Aerial Spraying operations are excluded from the coverage.

5. Types of Spraying Operations

Herbicide: _____	Days per Year: _____
Pesticide: _____	Days per Year: _____
Other (describe): _____	Days per Year: _____

6. Describe the methods of application used:

7. Do you require that the person conducting the spraying operations be certified? YES NO

8. Percentage of spraying operations performed by Employees? _____

9. Percentage of spraying operations performed by Contractors? _____

10. Do you required Certificates of Insurance from Spraying Contractors? YES NO

11. **Please attach Material Data Safety Sheets (MSDS's) for all chemicals used and list the quantities used for each.**

OTHER SERVICE WORK

12. Please list other service work routinely provided by the Applicant:

PUBLIC ENTITIES / EDUCATIONAL FACILITIES ENVIRONMENTAL INSURANCE APPLICATION

ADDENDUM H: Vehicle Maintenance Facilities

ENTITY: _____

**ONE ADDENDUM MUST BE COMPLETED FOR EACH LOCATION
LOCATIONS ARE NOT COVERED UNLESS SCHEDULED TO THE POLICY**

PROPERTY DESCRIPTION		
Physical Street Address	Year First Opened	Number of Vehicles Serviced each year
1. Is the facility used for other operations besides vehicle maintenance? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what operations? _____		
2. Does this location have hydraulic lifts? <input type="checkbox"/> YES <input type="checkbox"/> NO		
3. Have the hydraulic lift oil tanks ever been inspected? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please provide details:		
4. Provide a description of adjacent properties: North: _____ South: _____ East: _____ West: _____		
5. Identify any protected or sensitive environments within one mile of the site (parks, schools, wetlands, etc.):		
6. Is public water and sewer available at the site? <input type="checkbox"/> YES <input type="checkbox"/> NO		
7. Provide information regarding any mandatory or voluntary monitoring performed at the site:		
8. Identify any past storage or disposal practices at the site, including any on-site disposal:		
9. Please provide information on known prior uses of the maintenance locations:		
10. Are there any fuel storage tanks located at the site? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please complete Addendum G: Storage Tank Data Sheet.		

PUBLIC ENTITIES / EDUCATIONAL FACILITIES ENVIRONMENTAL INSURANCE APPLICATION

ADDENDUM I: Water Treatment Facilities / Wastewater Treatment Facilities

ENTITY: _____

**ONE ADDENDUM MUST BE COMPLETED FOR EACH LOCATION
LOCATIONS ARE NOT COVERED UNLESS SCHEDULED TO THE POLICY**

Entity: _____

Physical Address of Storage Tanks Listed Below: _____

City: _____ State: _____ Zip Code: _____

EPA I.D. #: _____

1. What type of facility is this? (Check one)

Water Treatment Facility Waste Water Treatment Facility

2. When was this facility designed and built? _____

3. What is the Total Population served by this facility? _____

4. When was this facility first permitted? _____

5. Is this site completely fenced and access restricted? YES NO

6. Are there any fuel storage tanks located at the site? YES NO
If YES, please complete **Addendum G: Storage Tank Data Sheet.**

WATER TREATMENT

7. How many miles of pipelines is the entity responsible for? _____

8. Average amount of water treated per day (gallons)? _____

9. Maximum capacity treated water per day (gallons)? _____

10. Number of: _____ Water Tanks _____ Water Towers

11. Source of Water Supply for this facility: _____

WASTEWATER TREATMENT

12. How many miles of sewer lines is the entity responsible for? _____

13. Average amount of waste treated per day (gallons)? _____

14. Maximum capacity treated waste per day (gallons)? _____

15. Please complete the following for each permitted effluent discharge:

POLLUTANT	PERMITTED MAXIMUM AMOUNT	DAILY AVERAGE AMOUNT

16. Where and how is your effluent discharged? _____

17. What is done with the residual by-product/sludge? _____

RECLAIMED WATER

18. Does the facility sell or distribute any Reclaimed Water? YES NO

If YES:

a. Average gallons of water reclaimed per day: _____

b. Percent Sold: _____ Percent reused by the entity: _____

19. Are signs posted in the area where reclaimed water is used? YES NO

20. On a separate page, describe the use and application of the reclaimed water. _____



Storage Tank Inventory By Location

(Completed as part of the Application for Insurance)

Facility Name _____ Facility Address _____ Facility ID # _____

(Complete schedule with symbols below)

	1	2	3	4	5	6
Tank #						
UST/AST						
Install Date Year						
Capacity (Gallons)						
Contents						
Tank Construction Material						
Overfill/Spill Protection						
Tank Leak Detection						
AST Diking & Base Construction						
Piping Construction Material						
Piping Leak Detection						

Contents

- B.** Unleaded Gasoline
- C.** Gasohol
- D.,F.,G.,H.** Diesel
- K.** Kerosene
- L.** Waste Oil/ Used Oil
- M.** Fuel Oil
- P.** Generic Gasoline
- Q.** Pesticide
- R.** Ammonia compound
- S.** Chlorine compound
- T.** Haz. Substance (CERCLA)
- U.** Mineral Acids
- V.** Grades 5&6 bunker 'C' oils
- W.** Petroleum-base additive
- X.** Misc. petroleum-base
- Z.** Other, Identify

Tank Construction

- C.** Steel
- E.** Fiberglass
- F.** FRP Clad Steel
- X.** Concrete
- Y.** Polyethylene
- Z.** Other EPA/DEP Approved
- G.** Cathodic Protection Sacrificial Anode
- H.** Cathodic Protection - Impressed Current
- I.** Double Walled(DW) - Single Material
- R.** Double Walled (DW)- Dual Material
- J.** (DW)Synthetic Liner in Tank Construction
- V.** (DW)Pipeless UST with Secondary Containment
- B.** Internal Lining **STI.** STI-P3

Overfill/Spill Protection

- A.** Ball Check Valve
- M.** Spill Containment Bucket
- N.** Flow Shut-off
- O.** Tight Fill
- P.** Level Gauges, High Level Alarms
- Q.** Other EPA/DEP Approved Protection Method
- Piping Construction Material**
- B.** Steel
- C.** Fiberglass
- F.,M.** Double walled
- N.** Approved Synthetic Material
- Z.** Other EPA/DEP Approved Piping Material
- D.** External Protective Coating
- E.** C/P with sacrificial anode or impressed current

Tank Leak Detection

- N.** Groundwater Monitoring Wells
- E.** Interstitial Monitoring
- O.** Vapor Monitoring Wells
- Q.** Visual Inspections of AST Systems
- Z.** Other EPA/DEP Approved
- D.** SPCC Plan - AST
- F.** Interstitial Space - Double Walled Tank
- M.** Manual Tank Gauging - UST
- S.** Statistical Inventory Reconciliation (SIR)(USTs)
- L.** Automatic Tank Gauging System (USTs)
- R.** Interstitial Monitoring of AST tank bottom
- T.** Annual Tightness Test with Inventory (USTs)

AST Diking & Base Construction

- K.** Concrete, Synthetic Material, clays
- S.** Other EPA/DEP approved secondary containment system
- Z.** Dirt/Earth

Piping Leak Detection

- G.** Electronic Line Leak Detector with Flow Shutoff
- J.** Interstitial Monitoring - Piping Filter
- 6.** External Monitoring
- H.** Mechanical Line Leak Detector
- K.** Interstitial Monitoring of double wall piping
- V.** Suction Pump Check Valve



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(Completed as part of the Application for Insurance)

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UNMANNED AIRCRAFT INSURANCE APPLICATION

Applicant's Name _____

Address _____
STREET
CITY
STATE/PROVINCE
ZIP/POSTAL CODE

Is this address located on, or adjacent to, an airport? Yes No

Effective from _____ until _____ Both at 12:01 AM standard time at the address above.

Business of Applicant _____ Number of Years in Business _____

Former Business Names _____

Applicant is: Individual(s) Partnership Corporation Holding Company Government
 Other (describe) _____

and is owned, controlled, or a subsidiary of _____

Is Applicant incorporated solely for ownership of the aircraft? _____

Has Applicant obtained a Certificate of Waiver or Authorization (CoA) from the FAA? Yes No

Name of last Aircraft insurance carrier (if none so state) _____ Exp. Date _____

Describe all incidents, accidents, claims (hull and liability) with dates and amounts paid (even if none), which occurred in the last five years.

Has any Insurance Company or Underwriter at any time declined an aircraft application submitted by or cancelled or refused to renew an aircraft policy held by the applicant or any of the pilots named herein? Yes No If so, explain. (Note: Missouri applicants Do Not Respond)

PILOT/OPERATOR NAME(S)

All pilots/operators who will regularly control the applicant's aircraft must complete a "UAS PILOT/OPERATOR QUALIFICATIONS" form:

MAINTENANCE

Is all maintenance performed on the aircraft, and its individual components, completed in accordance to manufacturer guidelines? Yes No

Is a record of all maintenance maintained? Yes No

LIABILITY COVERAGE	Limits of Liability Requested	
	Each Person	Each Occurrence
<input type="checkbox"/> Bodily Injury Liability	\$	\$
<input type="checkbox"/> Property Damage Liability	X X X X X	\$
<input type="checkbox"/> Single Limit Bodily Injury and Property Damage Liability	X X X X X	\$
<input type="checkbox"/> Crew Medical Payments	\$	\$
<input type="checkbox"/> Other Liability (Specify) _____	\$	\$

AIRCRAFT INFORMATION (If more than one unmanned aircraft is to be covered please complete this page for each)

PHYSICAL DAMAGE COVERAGE

	Amount of Insurance	Deductibles
<input type="checkbox"/> All Risk: Ground and Flight	\$ _____	<small>IN MOTION, IN FLIGHT, OR MOORED</small> <input type="checkbox"/> 5% <input type="checkbox"/> 10% <input type="checkbox"/> Other <small>NOT IN MOTION</small> \$ _____
<input type="checkbox"/> All Risk: Not in Flight	\$ _____	
<input type="checkbox"/> All Risk: Not in Motion	\$ _____	

Make and Model: _____

Registration Number (if applicable): _____ Manufacturer's Serial No. _____

If aircraft has no registration number or manufacturer's serial number, please describe how aircraft can be positively identified in the event of an incident, accident, or claim:

Date Purchased: _____ New or Used: _____ Price Paid: \$ _____

Present Estimated Value with all attached equipment/and any modifications made since purchase: \$ _____

Aircraft Type: Fixed-wing Rotor-wing Balloon Glider Single-engine Multi-engine
(CHECK ALL THAT APPLY)

Does this aircraft burn combustible fuel? Yes, type _____ No

Normal Control: Manually flown Semi-autonomous Fully autonomous

Type of launch: Traditional takeoff Hand Rail
 Other (please describe) _____

Type of recovery: Traditional landing Net/Line capture Parachute
 Other (please describe) _____

Maximum Gross Take-Off Weight (including all installed/carried equipment and payload (Specify lbs./Kg.)) _____

Wingspan/Rotor Diameter (Specify cm, in, feet, or meters) _____ Maximum Endurance (in hours) _____

Maximum Operating Altitude (in feet) _____ Maximum Range (Specify feet, yards, meters, miles, or kilometers) _____

Does the aircraft have the ability to independently detect and avoid other aerial traffic? Yes No

In the event of a lost link between the ground control station and the aircraft, does the UAV contain an automated recovery program that allows for it to safely return to a predetermined point? Yes (please describe procedure below) No

Are there redundancies built in for the aircraft's propulsion system? Yes No

Are there redundancies built in for the aircraft's flight control surfaces? Yes No

Are there redundancies built in for the aircraft's navigation/communication systems? Yes No

Aircraft Manufacturer's website: _____

Website (e.g. YouTube) where video of UAV can be viewed: _____

PURPOSE OF USE

CHECK ALL APPLICABLE USES

- | | | | |
|-------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Police | <input type="checkbox"/> Fire | <input type="checkbox"/> Search & Rescue | <input type="checkbox"/> Surveillance |
| <input type="checkbox"/> Photography | <input type="checkbox"/> Wildlife Observation | <input type="checkbox"/> Construction/Engineering | <input type="checkbox"/> Industrial |
| <input type="checkbox"/> Video/Film Production | <input type="checkbox"/> Communications | <input type="checkbox"/> Pipeline/Powerline Patrol | <input type="checkbox"/> Flight Testing/Demonstration |
| <input type="checkbox"/> Thermal Imagery | <input type="checkbox"/> Aerial Marketing | <input type="checkbox"/> Employee Training | <input type="checkbox"/> Crop Management |
| <input type="checkbox"/> Mapping | <input type="checkbox"/> Military (Non-Combat) | <input type="checkbox"/> Cargo/Freight Carrying | <input type="checkbox"/> Real Estate Sales |
| <input type="checkbox"/> Atmospheric/Weather Research | <input type="checkbox"/> List all other uses not indicated above (explain) | | |

If different from the Applicant's address, please provide the address of location where aircraft is/are normally stored

STREET

CITY

STATE/PROVINCE

ZIP/POSTAL CODE

Is this address located on, or adjacent to, an airport? Yes No

Describe the security measures and fire protection in place at the location where the aircraft is/are stored:

Who employs the pilot(s)/operator(s) of the aircraft to be insured? Applicant Other (explain) _____

Estimated number of hours the aircraft to be insured is/are to fly in the coming 12 months: _____ Number of flights/missions: _____

Does Applicant hangar/store, service, repair or crew other aircraft? _____ Describe _____

List all partners and owned, controlled, affiliated and subsidiary firms on separate sheet. List Attached

Has any applicant, or officer or partner thereof, or pilot/operator been convicted in or indicted in a legal action involving drugs? _____

Applicant is: Sole Owner of the aircraft Owner subject to mortgage or conditional sales contract
 Other - explain _____

If aircraft is mortgaged, name and address of mortgagee _____

Amount of mortgage (excluding interest and finance charges) \$ _____

Will Breach of Warranty Coverage be required by mortgagee? _____

Are any other Aircraft (manned or unmanned) owned by, rented or used by or on behalf of Applicant? _____

Model Aircraft _____ Uses _____ No. of hours per year _____

OPERATING ENVIRONMENT/CHARACTERISTICS

CHECK ALL APPLICABLE EXPOSURES

- Urban (City centers, heavily populated areas)
- Industrial (Near numerous non-residential buildings)
- Over water (rivers/ponds/small lakes)
- Night operations
- IFR weather operations
- Suburban/Semi-Urban (numerous nearby buildings/moderate population)
- Rural (Limited, if any, exposure to people and property)
- Over open water (large lakes/seas/oceans)
- Severe Weather
- Other (describe)

Does any pre- and/or in-flight communication with Air Traffic Control take place for a typical mission/flight? Yes No

How many visual observers are used for a typical mission/flight? (Do not include pilot/operator) _____

Maximum distance aircraft is anticipated to fly from ground control station (Specify feet, yards, meters, miles, or kilometers) _____

Maximum anticipated altitude (AGL) for typical mission/flight (Specify feet or meters) _____

Longest anticipated duration of any single-flight (in hours) _____

List all countries where missions/flights are anticipated to take place _____

For applicants anticipating missions/flights within the U.S., please list specific states where operations are expected: _____

FRAUD WARNINGS

(last updated 1/13)

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

FRAUD WARNINGS CONTINUED

NOTICE TO ALABAMA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: 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.

NOTICE TO COLORADO APPLICANTS: 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 AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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 ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN 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 MATERIAL 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.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: 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 OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

FRAUD WARNINGS CONTINUED

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.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: 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 (365:15-1-10, 36 § 3613.1).

NOTICE TO OREGON 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

X _____
Applicant's Signature

Today's Date

COWBELL CYBER RISK INSURANCE APPLICATION

PRIME 250

NOTICE: This application is for claims-made and reported coverage. With respect to Insuring Agreement C. This policy provides coverage on a claims made and reported basis and apply only to claims first made against the Insured during the policy period or the optimal extension period (if applicable) and reported to the Insurer in accordance with the terms of this policy. Amounts incurred as First Party Expense and First Party Loss under this policy with reduce and may exhaust the limit of liability and are subject to deductibles.

If a policy is issued, this application will attach to and become part of the policy. therefore, it is important that all questions are answered truthfully and accurately.

General Information

Name of Insured

Web Domain(s):

Address:

Industry:

Revenue (expected over the 12 months):

1. Security Assessment - (check appropriate box)

1. Does the organization assign a person responsible for information security? [Yes] [No]

2. Does the organization hold mandatory cybersecurity training with all employees at least annually? [Yes] [No]

3. Does the organization encrypt all external communications containing sensitive information? [Yes] [No]

4. Does the organization encrypt sensitive information stored on the cloud? [Yes] [No]

5.a. How often does the organization perform backups of business-critical data? [Weekly]
 [Monthly]
 [Quarterly]
 [Every 6 Months]
 [Never]

If your organization performs backups, please select all that apply

Backups are:

[Encrypted] [Tested] [Separate either offline or in a designated cloud service] [Other]

(Other: Please specify)

5.b. How often does the organization apply updates to critical IT-systems and applications (“security patching”)?	<input type="checkbox"/> [Weekly] <input type="checkbox"/> [Monthly] <input type="checkbox"/> [Quarterly] <input type="checkbox"/> [Every 6 Months] <input type="checkbox"/> [Never]
-------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

6. Do you enforce Multi-Factor Authentication (MFA) for all employees, contractors, and partners on the following? <i>If yes, please select all that apply</i> <input type="checkbox"/> [Email] <input type="checkbox"/> [Cloud Deployments] <input type="checkbox"/> [Mission-Critical Systems] <input type="checkbox"/> [Other] <i>(Other: Please specify)</i> <div style="border: 1px solid #ccc; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------

7. Does the organization have an incident response plan - tested and in-effect - setting forth specific action items and responsibilities for relevant parties in the event of a cyber incident or data breach matter?	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------

2. Past Activities - (check appropriate box)

1. Has the organization filed any claims due to a cyber event in last five years? If yes, attach loss detail herewith.	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------

2. Has the organization ever been a party to any of the following: a. Civil or criminal action or administrative proceeding alleging violation of any federal, state, local or common law? b. Is there currently any pending litigation, administrative proceeding or claim against the named applicant, organization and/or any of the prospective insureds?	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No] <input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------

3. During the last three years, has the organization suffered loss of business income as a result of unscheduled system downtime?	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
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4. During the last three years, has the organization suffered a security breach requiring customer or third-party notification according to state or federal regulations?	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
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3. Optional: Cyber Crime (applicable only for I.B.5.) - (check appropriate box)

1. Does the organization verify vendor/supplier bank accounts before adding to their accounts payable systems?	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
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2. Does the organization authenticate funds transfer requests (e.g. by calling a customer to verify the request at a predetermined phone number)?	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
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3. Does the organization prevent unauthorized employees from initiating wire transfers?	<input type="checkbox"/> [Yes] <input type="checkbox"/> [No]
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4. Optional: System Failure Contingent Business Interruption Loss (applicable only for I.B.4.) - (check appropriate box)

1. Are all internet-accessible systems (e.g. web-, email-servers) segregated from the organization's trusted network (e.g. within a demilitarized zone (DMZ) or at a third-party service provider)? [Yes] [No]

2. Do agreements with third-party service providers require levels of security commensurate with the organization's information security standard? [Yes] [No]

5. Optional Endorsement: Full System Failure - (check appropriate box)

1. How often does the organization perform backups of business-critical data? [Weekly]
 [Monthly]
 [Quarterly]
 [Every 6 Months]
 [Never]

If your organization performs backups, please select all that apply

Backups are:

[Encrypted] [Tested] [Separate either offline or in a designated cloud service] [Other]

(Other: Please specify)

2. Are all internet-accessible systems (e.g. web-, email-servers) segregated from the organization's trusted network (e.g. within a demilitarized zone (DMZ) or at a third-party service provider)? [Yes] [No]

3. Has the organization tested a full failover of the most critical servers? [Yes] [No]

Notice to Applicant - Please Read Carefully

For the purpose of this Application, the undersigned authorized officer of the organization named in Section I. of this Application declares that, to the best of the organization's knowledge, the statements herein are true, accurate and complete. The insurer is authorized to make any inquiry in connection with this Application. Signing this Application does not bind the insurer to issue, or the applicant to purchase, any insurance policy issued in connection with this Application. The information contained in and submitted with this Application is on file with the insurer. The insurer will have relied upon this Application and its attachments in issuing the Policy. If the information in this Application materially changes prior to the effective date of the Policy, the applicant will promptly notify the insurer, who may modify or withdraw the quotation. The undersigned declares that the individuals and entities proposed for this insurance have been notified that the limit of liability is reduced by amounts incurred as "Defense Expenses" (as defined in the Policy), and such expenses will be subject to the deductible amount. Misrepresentation of any material fact in this Application may be grounds for the rescission of this Policy.

 **Fraud Warnings****General Fraud Warning**

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. (Not applicable in AL, AK, AZ, AR, CA, CO, DE, DC, FL, ID, IN, HI, KS, KY, LA, ME, MD, MN, NH, NJ, NM, NY, OH, OK, OR, PA, PR, RI, TN, TX, UT,, TN, TX, UT, VA, VT, WA and, WV)

Alabama Fraud Warning

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

Alaska Fraud Warning

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona Fraud Warning

For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas Fraud Warning

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.

California Fraud Warning

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Fraud Warning

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.

Delaware Fraud Warning

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

District Of Columbia Fraud Warning

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 addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Fraud Warning

Any person who, knowingly and with intent to injure, defraud, or deceive an 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.

Idaho Fraud Warning

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

Indiana Fraud Warning

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Hawaii Fraud Warning

For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

Kansas Fraud Warning

We will not pay for any loss or damage if you or any other insured in relation to an insurance application, rating, claim or coverage under this policy knowingly and with intent to defraud: 1. Presents, causes to be presented or prepares with the 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 material fact; or 2. Conceals information concerning any material fact for the purpose of misleading.

Kentucky Fraud Warning

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.

Louisiana Fraud Warning

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.

Maine Fraud Warning

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, or a denial of insurance benefits.

Maryland Fraud Warning

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

Minnesota Fraud Warning

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

New Hampshire Fraud Warning

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey Fraud Warning

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

New Mexico Fraud Warning

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 civil fines and criminal penalties.

New York Fraud Warning

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.

Ohio Fraud Warning

Any person who, with intent to defraud or knowing that he 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.

Oklahoma Fraud Warning

WARNING: 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.

Oregon Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. In order for us to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on your part, we must show that: A. The misinformation is material to the content of the policy; B. We relied upon the misinformation; and C. The information was either: 1. Material to the risk assumed by us; or 2. Provided fraudulently.

For remedies other than the denial of a claim, misstatements, misrepresentations, omissions or concealments on your part must either be fraudulent or material to our interests. Misstatements, misrepresentations, omissions or concealments on your part are not fraudulent unless they are made with the intent to knowingly defraud.

Pennsylvania Fraud Warning

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.

Puerto Rico Fraud Warning

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 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 with the penalty of a fine 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.

Rhode Island Fraud Warning

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.

Tennessee Fraud Warning

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.

Texas Fraud Warning

Workers Compensation: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Utah Fraud Warning

Workers Compensation: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont Fraud Warning

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia Fraud Warning

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.

Washington Fraud Warning

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.

West Virginia Fraud Warning

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.



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

Signature**Date (MM/DD/YYYY)****Name of Authorized Representative****Title****Insured Name****Email**



STATEWIDE INSURANCE FUND

A JOINT INSURANCE FUND SERVING NEW JERSEY'S COMMUNITIES SINCE 1994

30A Vreeland Road , P.O. Box 678
Florham Park, New Jersey 07932-0678
973-549-7997 Fax 973-966-8663

Re: Fire Companies, First Aid Squads and other Non-Profit Organizations

In previous years we have corresponded concerning the insurance coverage for entities outside of the municipalities who are members of the Fund. There is a close association between the fire companies, first aid squads and other non-profit organizations and sometimes it is not clear who is responsible for the insurance coverage. In certain situations, the fire companies or first aid squads are separate entities but the vehicles are purchased by the town, titled and registered to the town, and therefore listed on the town's insurance schedule. In other instances, the towns purchase the vehicles, but the title and registration are in the name of the department.

Workers Compensation

The statute specifically allows a municipality to provide coverage for a separate fire company or first aid squad. Please note this coverage is not automatic and any member that does not currently provide the coverage under the Statewide Insurance Fund would need to specifically request the coverage. The addition of the coverage is subject to underwriting review and approval.

Emergency volunteers are the only volunteers who are eligible for workers compensation coverage through the entity. This is governed by the statute. N.J.S.A. 34:15-74 states a municipality is required to provide workers compensation insurance for volunteer firemen and volunteer first aid squad members, working under the supervision of any municipal governing body. However, a volunteer fire company or rescue squad may elect to obtain its own insurance coverage (N.J.S.A. 34:15-74.1)

Vehicle Coverage

The eligibility for coverage for vehicles is also dictated by statute. N.J.S.A. 40A:10-3 states a municipality is required to provide insurance coverage to "operators of all motor vehicles, equipment and apparatus owned by or under its controls, or owned by or under the control of any of its departments, boards, agencies or commissions.

However, in accordance with N.J.S.A. 40A:10-2, for vehicles not owned by the municipality, the municipality **can** provide the following insurance to a volunteer or incorporated fire department or rescue squad, by paying the entire premium or a portion thereof:

- a. Covering their motor vehicle, equipment and apparatus against loss or damage however caused;
- b. Against all liability arising from the ownership, use or operation of their motor vehicles, equipment and apparatus; or,
- c. Both

Additional All Lines (General Liability, Property, Crime, Professional Liability, Cyber, etc)

With respect to the All Lines Coverage the criteria to be considered eligible to be insured with the municipality's insurance is as follows:



STATEWIDE INSURANCE FUND

A JOINT INSURANCE FUND SERVING NEW JERSEY'S COMMUNITIES SINCE 1994

30A Vreeland Road, P.O. Box 678
Florham Park, New Jersey 07932-0678
973-549-7997 Fax 973-966-8663

1. The entity must be a governmental agency or subdivision, department, municipal body, board or commission, or not for profit corporation which is owned and controlled by the municipality **and is part of the municipality's operating budget**. Granting funding or a stipend for operations is not considered part of their operating budget.
2. As an agency of the municipality, the entity is subject to the provisions of the Local Public Contract Law;
3. The entity was created by an act of the governing body of the member municipality or
4. The entity is subject to the provisions of the Local Fiscal Affairs Law, Local Budget Law and any full time paid employees of the entity are eligible for membership in the Public Employees Retirement System.

For example, ABC town's rescue squad is an independent non-profit organization and they have 20 volunteers and own 3 vehicles that are titled and registered to the squad. The volunteers are eligible to be insured for workers compensation with the town and the vehicles are eligible to be insured on the town's automobile coverage. General liability, building coverage, directors and officers, etc. would need to be purchased separately by the squad.

Operations such as outside sport or recreational league programs would not be eligible for all lines coverage unless they meet the criteria above.

To apply for coverage, please verify the following:

1. Please submit the attached form for each entity.
2. Confirm that all property/automobiles listed on the SOV are registered to the municipality or entity that is eligible to participate in the municipality's insurance.

How towns choose to deal with the exposures relating to these types of entities can change on a regular basis and often they are not aware of the consequences relating to insurance. Therefore, we recommend that you address this issue on an annual basis. For those emergency services entities that are not included, we recommend that the following information be confirmed:

1. For any fire department in which the Council approves the issuance of blue light permits, but where the fire department is separately insured, please obtain a certificate of as evidence of insurance.
2. For any fire department, rescue or ambulance squad in which the automobiles are registered to the municipality but the department and squad are separately insured, a certificate of insurance should be provided to the municipality as evidence of insurance.
3. Insurance coverage for 1 & 2 above should include but not be limited to automobile liability, non-owned and hire automobile liability, general liability, errors and omission (Professional liability) and Directors and Officers including employment practices liability.

If you have any questions or concerns about coverage for a specific entity, feel free to call our office.

Statewide Insurance Fund

Supplemental Application for Municipal Organizations

Member Name: _____

Please complete this page for each organization that is to be included as an insured.

Name of Organization	Address	Contact Person	Telephone #
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What best describes the organization?

- Fire Suppression Only
- Rescue/EMS or Ambulance Squad
- Fire and Rescue
- Club Organization, Association
- Other

This organization is:

- Municipal Department
- Municipally Controlled
- Independent Non Profit
- Shared Service
- Taxing Entity

If Other, Please Describe: _____

Please Indicate Type of Coverage Requesting:

- Workers Compensation
- Property
- Automobile Physical Damage

- General Liability
- Automobile Liability
- Professional Lines

List Other Insurance Coverage in Place:

Carrier	Coverage Type	Effective Date	Policy Number
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Completing this form does not convey coverage. Newly submitted entities must be approved in writing by Statewide Insurance Fund

Completed By: _____

Date: _____

Position: _____

Page: _____ **of** _____