J.J. NEGLEY
ASSOCIATES•INC
UNDERWRITING MANAGERS

388 Pompton Avenue, P.O. Box 206, Cedar Grove, NJ 07009
(973) 239-9107 • Fax: (973) 239-6241

PROFESSIONAL & GENERAL LIABILITY APPLICATION

APPLICATION
FOR PROFESSIONAL & GENERAL LIABILITY INSURANCE

For this application to be processed in a timely fashion, please answer *every* question completely. If a question is not applicable, please write N/A. Do not leave any space blank.

1. Name of Insured _____

2. Mailing Address:

   Street _____ County _____

   City _____ Phone _____

   State _____ Zip _____

3. Type of Organization:

   Individual _____ Partnership _____

   Corporation, for profit _____ Corporation, nonprofit _____

4. Describe the purpose of the organization (attach brochures) _____

   _____

5. If more than one Named Insured listed above, please explain the ownership and operational relationships.

   _____

6. Number of years in operation _____.

7. Projected operating budget $_____. **Include current Audited Financial Statement.**

8. Current Insurance:

Professional Liability	**General Liability**
Company _____	Company _____
Inception Date: _____ Expiration Date: _____	Inception Date: _____ Expiration Date: _____
Premium $ _____	Premium $ _____
Deductible $ _____	Deductible $ _____
Limit of Liability $ _____	Limit of Liability $ _____
Occurrence Form? _____ or Claims Made? _____	Occurrence Form? _____ or Claims Made? _____
If Claims Made form, Retroactive Date _____	If Claims Made form, Retroactive Date _____

9. Limits Requested: Professional Liability $ _____ General Liability $ _____

10. Has any company cancelled or declined to renew insurance? _____.

    If yes, please explain. _____

11. Have there been any claims or lawsuits in the last five years? ____Yes ____No If yes, give details below:

    Date of Loss **Amount Paid or Reserved** **Claimant's Name/Description of Incident** (Attach separate sheet if necessary)

    _____

    _____

    _____

    _____

12. Are there any circumstances known which may give rise to a claim or lawsuit? ____Yes ____No

    If yes, explain. _____

13. Has any license or accreditation ever been suspended, denied or revoked? _____

14. Of what professional association(s) is Insured a member in good standing? _____

_____

15. Schedule of Employees:

	Number of Full Time	Part Time
Administrators	_____	_____
Clerical	_____	_____
Counselors	_____	_____
Homemakers/Aides	_____	_____
Nurses	_____	_____
Psychologists	_____	_____
Social Workers	_____	_____
Students	_____	_____
Volunteers	_____	_____
Others, please specify_____	_____	_____
_____	_____	_____

16. Schedule of Physician Staff: (If none, write "none"_____)

Name	Contracted and Employed Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed *(V, C or E)*	Carries own Malpractice Insurance Yes	No
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐

17. Do you wish physicians to be covered under the Center's policy? ☐ Yes ☐ No.

18. Are drugs or medication administered or prescribed? ☐ Yes ☐ No. If yes, Please explain. _____

_____

_____

19. Is electroshock therapy utilized? ☐ Yes ☐ No. If yes, how many per year? _____

20. Schedule of Locations: (Attach separate sheet if necessary.)

Loc. No.	Complete Address (including zip code)	Sq. Feet	Type of Services Provided
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____		

21. List of Additional Insureds: (If none, write "none"_____)

Name and Address (including zip code)	Interest
_____	_____
_____	_____
_____	_____
_____	_____

22. Units of Service - The number of units of each service rendered by the facility should be entered below, where appropriate:

Please indicate the number of **Beds.**

Mental Health Inpatient	_____	Group Home	_____
Alcohol/Drug Inpatient	_____	Shelters	_____
Alcohol/Drug Detox.	_____	Independent Living	_____
Halfway House	_____	Foster Care	_____
		Other, please specify	_____

Please indicate the number of **Annual Outpatient or Client Visits.**

Alcohol/Drug Rehab.	_____	Counseling	_____
Mental Health	_____	Other, please specify	_____
Methadone	_____		

Please indicate number of **Clients per Day.**

Adult Day Care	_____	Partial Hospitalization	_____
Child Day Care	_____	Sheltered Workshops	_____
		Other, please specify	_____

Please indicate number of **Calls, Annually.**

Hotline	_____	Information	_____
Referral	_____	Other, please specify	_____

Please indicate number of **Annual Employee Assistance Programs (EAP) Contacts or Visits.**

Assessments	_____	Counseling Visits	_____
Referrals	_____	No. of Companies under Contract	_____

Please indicate number of **Home Health Care Visits.**

Nonprofessional Hours	_____	IV Therapy	_____
Professional Hours	_____		

23. Attach an application supplement for the following classes of service:

Residential or Inpatient (one supplement per location)	Day Care, Pre-School, Headstart
Foster Care/Adoption	Sheltered Workshops/Products

24. Are there any camp, adventure/wilderness, ropes courses, or any type of recreational programs? If yes, please provide descriptive material._____

25. Are there any swimming or boating activities? If yes, please provide details. _____

---

26. **Very Important** — Please attach copies of all available descriptive materials and/or brochures on your operations.

It is agreed this form will be the basis of the contract should a policy be issued. This form will be attached to and become a part of the policy.

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 penalities.

APPLICABLE IN THE STATE OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Executive Director _____/_____Date _____
Please print or type name

Person to contact regarding this application _____ Phone _____

(PRODUCER: Will you make the surplus line filing for this policy? ____Yes ____No
Your Surplus Lines Number _____)

10/95

J. J. NEGLEY
ASSOCIATES•INC
UNDERWRITING MANAGERS

388 Pompton Avenue, P.O. Box 206, Cedar Grove, NJ 07009
(973) 239-9107 • Fax: (973) 239-6241

RESIDENTIAL OR INPATIENT FACILITY SUPPLEMENTAL APPLICATION

(To be completed for each applicable location.)

1. Applicant_____

   Location Number_____ Address_____

2. Number of Beds _____ (Licensed Capacity) _____ (Occupied)

3. Is there 24 hour supervision? ☐ Yes ☐ No

   Please explain the supervision procedures:_____

   _____

   _____

4. Does hiring procedure include background/reference check? ☐ Yes ☐ No

   Screening for criminal record? ☐ Yes ☐ No

5. Is treatment provided at this location? _____ If yes, please describe: _____

   _____

   _____

6. Number of Nonambulatory residents _____

7. Average length of stay _____ Age Group _____ Sex: _____M _____F

8. What types of residents are housed or treated in this facility?

   Alcohol _____ Mentally Ill _____ Aged _____

   Drug _____ Mentally Retarded _____ Other _____

9. Are the residents screened by a physician prior to admission? ☐ Yes ☐ No If not, please describe the procedure which determines who is eligible for admission_____

   _____

   _____

   _____

10. Construction of building _____ Number of stories _____ Sq. Ft. _____

11. Is there a secondary means of egress from all upper floors? ☐ Yes ☐ No

12. Are there smoke detectors? ☐ Yes ☐ No

13. Is there a fire alarm system? ☐ Yes ☐ No

J. J. NEGLEY
ASSOCIATES•INC
UNDERWRITING MANAGERS

388 Pompton Avenue, P.O. Box 206, Cedar Grove, NJ 07009
(973) 239-9107 • Fax: (973) 239-6241

Foster Care / Adoption Supplemental Application

Applicant _____

Address _____

How many foster care homes are utilized? _____ Total number of beds available _____

Maximum number of children per home _____ Age range of foster children _____

Foster parents are: ☐ employees ☐ independent contractors

Does foster parent carry individual liability insurance? ☐Yes ☐N

If yes, does the insured obtain Certificates of Insurance? ☐Yes ☐N

Who licenses these foster homes? _____

Does the insured certify the foster homes? ☐Yes ☐

Criteria upon which a foster home is rated and accepted: _____

_____

_____

Does acceptance procedure include background / reference check? ☐Yes

If yes, how are the references verified? _____

Are police records checked? ☐Yes

7. How often do social workers visit a foster home? _____

8. Annual number of adoptions _____

From whom (e.g., agencies, private parties) does the agency receive adoptive children? _____

_____

_____

9. Please attach brochures, foster care and adoptive protocol.