



**Philadelphia Insurance Companies**  
 One Bala Plaza, Suite 100, Bala Cynwyd, Pennsylvania 19004  
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**SOCIAL SERVICES ORGANIZATION  
 SUPPLEMENTAL APPLICATION**

PLEASE ATTACH THE FOLLOWING (✓)

- |   |   |
|---|---|
| <input type="checkbox"/> ACORD Applications, including Crime & Umbrella       | <input type="checkbox"/> Loss Runs for Current Year and 3 Prior Years |
| <input type="checkbox"/> Statement of Values                                  | <input type="checkbox"/> Brochure and/or Newsletter                   |
| <input type="checkbox"/> Schedule of Vehicles                                 | <input type="checkbox"/> Financial Statement if For Profit            |
| <input type="checkbox"/> Drivers List with License Numbers and Dates of Birth | <input type="checkbox"/> Photographs – Residential Locations          |

Named Insured: \_\_\_\_\_

Insured Contact Name for Billing Information: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Sic #: \_\_\_\_\_ Fein #: \_\_\_\_\_ Website Address: \_\_\_\_\_

Production Underwriter: \_\_\_\_\_ Non-Profit \_\_\_\_\_ For Profit \_\_\_\_\_

Number of years this facility has been: \_\_\_\_\_ In Operation \_\_\_\_\_ Under Present Management \_\_\_\_\_

**A. LIFE SAFETY SECTION:**

- Do all of your facilities (buildings) have the following Life Safety Features? **Yes/No** If not, please indicate which location numbers.
- |  |  |       |
|--|--|-------|
| 1) Fire Alarms   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 2) Smoke Detectors   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Hard Wired   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Battery Operated   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 3) Emergency Lighting  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 4) Sprinklers  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 5) Are evacuation routes posted throughout the building?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 6) In the event of an evacuation, have you established a central meeting point outside the building? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 7) Are exit signs illuminated?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 8) How often are fire drills held?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 9) Are there at least two exit doors per building?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 10) Are exit doors equipped with panic hardware?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 11) Is smoking permitted inside the premises?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

**B. GENERAL LIABILITY SECTION:**

- |   |                             |
|---|-----------------------------|
| 1) Annual Operating Budget _____  | 2) Annual Payroll _____     |
| 3) Number of clients/customers per year _____   | 4) Number of Students _____ |
| 5) If providing residential services, provide number of beds at each location _____   |                             |
| 6) Do you have sheltered workshops? <input type="checkbox"/> Yes <input type="checkbox"/> No Indicate location number _____ |                             |
| Describe the work being performed _____   |                             |

Do you have mobile work forces, i.e. janitorial services?  Yes  No or landscaping services?  Yes  No  
 Other \_\_\_\_\_

If yes, please provide payroll: Janitorial \_\_\_\_\_ Landscaping \_\_\_\_\_ Other \_\_\_\_\_

Is Workers Compensation carried for clients?  Yes  No

7) Do you have a day care program  Yes  No Indicate location number(s) \_\_\_\_\_

Maximum number of children supervised \_\_\_\_\_ Ratio of children to Staff \_\_\_\_\_ Age Range \_\_\_\_\_

8) Do you provide any foster care or adoption services?  Yes  No If Yes, please explain \_\_\_\_\_

9) Are any locations leased to others?  Yes  No Indicate location number \_\_\_\_\_ Square Feet \_\_\_\_\_

10) Do you have any swimming pools?  Yes  No Indicate location number \_\_\_\_\_ Diving Board/Slide?  Yes  No

11) Do you sponsor any special fund-raising events?  Yes  No Are alcoholic beverages served?  Yes  No  
Provide full details (location, dates, attendance, description of events, etc.) \_\_\_\_\_  
\_\_\_\_\_

12) Have all buildings built prior to 1971 been inspected for lead paint?  Yes  No If "No", what is plan for abatement \_\_\_\_\_  
\_\_\_\_\_

13) Are counseling services/ therapy offered for the following target classes : Sexual Offenders?  Yes  No Sexual Predators?  Yes  No

**C. ABUSE & MOLESTATION**

1) Does your employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child abuse related offenses?  Yes  No

2) Do you request criminal background investigations for all applicants?  Yes  No If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

3) Do you verify employment related references?  Yes  No

4) Do you have a plan of supervision that monitors staff in day-to-day relationships with clients both on and off premises?  Yes  No

5) a. Has your organization ever had an incident which resulted in an allegation of sexual abuse?  Yes  No If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

b. Was a claim made against the organization?  Yes  No Was a claim made against any employee(s)?  Yes  No If yes, is that individual still employed with your organization?  Yes  No

c. Was the case settled?  Yes  No If Yes, please explain \_\_\_\_\_  
\_\_\_\_\_

6) Does your current insurance program exclude Abuse & Molestation coverage?  Yes  No If not, please indicate the limit of liability provided \_\_\_\_\_  
\_\_\_\_\_

**D. PROFESSIONAL LIABILITY**

Total No. of Full Time Employees \_\_\_\_\_ Total No. of Part Time Employees \_\_\_\_\_ Total No. of Volunteers \_\_\_\_\_

Does your current insurance program provide Professional Liability coverage?  Yes  No If Yes, indicate the limit of liability \_\_\_\_\_

Is Professional Liability  occurrence  claims made

Position	# of Full Time	# of Part Time	Position	# of Full Time	# of Part Time
Administrators			Clerical		
Counselors (Including Group Home Manager)			Teachers		
Psychologists			Physicians		
Nurses R.N.			Psychiatrists		
Nurses L.P.N.			Therapists		
Home Health Aides			Other:		
Social Workers			Other:		

Do the physicians carry their own malpractice insurance?  Yes  No  N/A

Indicate Company: \_\_\_\_\_ Limits of Liability: \_\_\_\_\_

Effective dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**E. CONSULTANTS/INDEPENDENT CONTRACTORS:**

Please indicate which of the following contracted service providers are utilized:

- Physicians  Nurse Practitioner
- Dentist  Optometrist
- Psychiatrist  Other \_\_\_\_\_

1) Are there written agreements with independent contractors?  Yes  No

2) Are certificates of malpractice/liability insurance obtained and maintained for all contracted service providers (independent contractors)?  
 Yes  No

3) Please indicate the limits of liability: \_\_\_\_\_  
\_\_\_\_\_

**F. AUTOMOBILE SECTION:**

1) What percentage of employees/volunteers use their own vehicles regularly (daily/weekly) for agency business?

% Employees \_\_\_\_\_ % Volunteers \_\_\_\_\_

