Insurance Application

J. Smith Lanier & Co.
Insuring People and Business Since 1868

Please email completed application to: Chris Walker at cwalker@jsmithlanier.com or Barber Wilson at bwilson@jsmithlanier.com. Phone 800-226-4518 / Fax 706-576-5607

Please include the following with this completed & signed supplemental application:

- Loss runs for current year and 4 years prior which are currently dated
- Schedule of property showing all locations and values
- If autos, a full schedule of vehicles (year, make, model, VIN)
- Drivers list with names, license numbers, and dates of birth
- Photographs of the Applicant's locations
- Descriptive brochures, publications, newsletters and/or website information
- Copies of current policy declaration pages
- Most recent financial statement

SECTION I – GENERAL APPLICANT INFORMATION

Applicant Name: ____

Website: ______________________________________ **Email:**____

SIC Code: _____________________________________ **FEIN:** ____

Contact Person for Inspection: ____

Full description of all operation(s) and types of clients served:

Type of entity: ❒ Non-Profit ❒ For Profit

Number of years in operation*: ___________ **Years under present management:** ___________
**If new in operation, please send a copy of the director's resume.*

Licensed by **:____
***Attach copy of state or governmental license(s)*

Has your license ever been suspended or revoked? If Yes, attach copy of Authority's report. ❒ Yes ❒ No

Have there been claims that allege negligence or failure to comply with any regulatory/licensing guidelines? ❒ Yes ❒ No
If Yes, provide details and explanation:

Primary funding source: ❒ Federal ❒ State ❒ County ❒ Other ______________________________________

Annual operating budget: _________________________ **Annual payroll:** _________________________________

Does the entity have: ❒ Budget Deficit ❒ Operational Reserves
If Budget Deficit, please explain:

SECTION I – GENERAL APPLICANT INFORMATION (CONTINUED)

Indicate whether the Applicant's employees or independent contractors provide the following services for the Applicant's clients:

❒ Landscaping ❒ Janitorial/Maintenance ❒ Re-paving/Re-surfacing ❒ Snow removal ❒ Other: ______________________

Professional organization memberships or affiliations: ____

Have you ever discontinued any programs? ❒ Yes ❒ No If Yes, provide details and explanation, including dates:

Are you aware of ANY claims, allegations, and/or incidences (including abuse & molestation) made against your organization, or against anyone working on your behalf that may give rise to a claim in the past five (5) years? If Yes, please provide details including dates, current status, amount paid/incurred, and resulting organizational/policy changes implemented as a result (attach additional page if necessary). ❒ Yes ❒ No

SECTION II – MANAGEMENT PRACTICES

1. Is the staff required to report to the administrator all incidences that may result in a claim? ❒ Yes ❒ No
2. Are written records of all incidences kept by the administrator?
3. Are all incidences reviewed? ❒ Yes ❒ No
4. Do you have a formal written safety program in place? ❒ Yes ❒ No
5. Does the facility have a written emergency evacuation plan? **If Yes, attach a copy.** ❒ Yes ❒ No
6. Do you have a plan in place for medical emergencies? ❒ Yes ❒ No
7. Is there always someone trained in CPR and first aid on the premises? ❒ Yes ❒ No
8. Do you have AED(s)?
   Are staff members trained to use AED(s)? ❒ Yes ❒ No
9. Do you have a written and enforced Smoking Policy? ❒ Yes ❒ No
   Are "no smoking" signs posted in areas not designated for smoking? ❒ Yes ❒ No
10. What type of method do you use for de-escalation? ____
    How often is the staff recertified? ____
11. Do you have any security provided for protection of your clients/residents? ❒ Guards ❒ Video Cameras ❒ Other
12. Do you have sign in/sign out procedures for: ❒ Staff ❒ Clients/Residents ❒ Visitors/Public
13. Have the police and / or fire departments been called to any of the Applicant's premises in the past three (3) years? ❒ Yes ❒ No
    If yes, please explain: ____
14. What measures are taken to monitor client activities?____
15. What precautions does the Applicant take to prevent non-staff members from accessing unauthorized areas of the property?

SECTION III – PROFESSIONAL LIABILITY

1. Hiring Practices:
   a. Are formal written procedures in place for staff hiring? ❒ Yes ❒ No
   b. Do you require your staff to complete an employment application? ❒ Yes ❒ No
   c. Do you conduct a personal interview for each prospective staff member? ❒ Yes ❒ No
   d. Are any staff members under 18 years of age? If Yes, list their position(s) and how they are supervised: ❒ Yes ❒ No

   e. Do you verify employment related references? ❒ Yes ❒ No
   f. Do you verify licenses and other credentials? ❒ Yes ❒ No
   g. Do you obtain criminal background checks, which check at least 10 years of data from 50 states, on ALL staff before start date? ❒ Yes ❒ No
   h. Do you require drug tests on all staff members, including drivers? ❒ Yes ❒ No
   If Yes: ❒ Before Hiring ❒ After Hiring ❒ Random
   i. What are the Applicant's procedures for evaluating all these reports?

   j. What actions do you take if any of these reports are unfavorable?

2. Do you share written job descriptions with all staff members? ❒ Yes ❒ No
3. Name of executive director/manager:____
   Number of years in this field: ______________________ Number of years at this facility: ______________________
4. Is there formal staff training? ❒ Yes ❒ No
5. Are files maintained to protect the confidentiality of clients? ❒ Yes ❒ No
6. Do you perform any consulting work? If Yes, explain: ❒ Yes ❒ No

7. Are clients referred to specialists when appropriate? ❒ Yes ❒ No
8. Do you have volunteer workers? If Yes, complete the section below: ❒ Yes ❒ No
   Is a complete background check required for all volunteers the same as for employees? If no, please explain: ❒ Yes ❒ No

   Are any volunteers working-off court-mandated community service? If yes, please explain: ❒ Yes ❒ No

SECTION III – PROFESSIONAL LIABILITY (CONTINUED)

9. Indicate number of staff (please complete the following table for Professional Liability):

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Administrator								
Child Care Worker								
Clergy								
Clerical/Office Staff								
Counselor (other)								
Home Health Aide								
Nurse Practitioner								
Nurse–LPN								
Nurse–RN								
Nutritionist								
Physician								
Psychiatrist								
Psychologist								
Resident Manager								
Social Worker – Bachelors (BSW)								
Social Worker – Masters (MSW)								
Teacher/Tutor/Aid								
Therapist–Occupational								
Therapist–Physical								
Therapist–Speech/Hearing								
Other Positions (specify):								
Other Positions (specify):								

10. Are there written agreements with independent contractors? ❒ Yes ❒ No
11. Are certificates of malpractice/professional liability insurance obtained and maintained for all contracted service providers (independent contractors)? ❒ Yes ❒ No
12. Please indicate the limits of liability: $ ___________
13. What are the minimum qualifications required for direct care/residential and group caregivers?

    a. Do you require all direct care staff to take First Aid and CPR training? ❒ Yes ❒ No
    b. Is initial and continuing training provided to direct care staff? ❒ Yes ❒ No
14. Do you provide specialized restraint training for your staff? ❒ Yes ❒ No

SECTION IV – ABUSE AND MOLESTATION

1. Does your staff 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 have written procedure for dealing with physical and sexual abuse? **If Yes, attach a copy.** ❒ Yes ❒ No
3. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients both on and off-premises? ❒ Yes ❒ No
4. Are procedures in place to avoid one-on-one situations so that more than one employee/volunteer is present at all times when a child is in your care? ❒ Yes ❒ No
5. Is there documented formal staff training on child/sexual abuse, including how to recognize the signs and how to report a known or suspected incident? ❒ Yes ❒ No
6. Indicate annual number of clients in each age range for all programs/services:

   0-8 years: ______ 9-18 years: ______ over 18 years: ______

SECTION V – PREMISES/LIFE SAFETY

1. If the building the Applicant occupies was built prior to 1971; has it been inspected for lead paint? ❒ Yes ❒ No
   If no, what is the plan for abatement? ____

2. Does the Applicant have any plans for renovations or new construction? If yes, please explain: ❒ Yes ❒ No

3. Does the Applicant have the following in place?

Fire alarms?	❒ Yes ❒ No	Central Station?	❒ Yes ❒ No
Security alarm?	❒ Yes ❒ No	Central station?	❒ Yes ❒ No
Smoke detectors?	❒ Yes ❒ No	Are smoke detectors:	❒ Hard Wired ❒ Battery Operated

4. Number of fire extinguishers on premises: ______ How often and by whom are they serviced? ______________________

5. How many means of egress are there? ________ Are all exits clearly marked & illuminated? ❒ Yes ❒ No

6. Are all exit doors equipped with panic hardware? ❒ Yes ❒ No

7. Is there a fire escape? If yes, describe: ❒ Yes ❒ No

8. Does the Applicant have a written emergency evacuation plan? ❒ Yes ❒ No
   If yes, are the emergency evacuation procedures and floor plan posted? ❒ Yes ❒ No
   Have Applicant established a central meeting point outside the building? ❒ Yes ❒ No
   Does the emergency plan include notification to the fire department? ❒ Yes ❒ No
   How often are drills held? ____

9. Does the Applicant have emergency lighting or backup generators in the event of a power failure? ❒ Yes ❒ No

10. Does the Applicant have a formal maintenance housekeeping program in place? ❒ Yes ❒ No

12. Does the Applicant own or rent parking facilities? ❒ Yes ❒ No Are they well lit? ❒ Yes ❒ No

13. Is the hot water heater set to a temperature of 120 degrees? ❒ Yes ❒ No
    Does the Applicant have an equipment maintenance program in place? ❒ Yes ❒ No

14. Has the Applicant's facility been inspected by an insurance company or independent inspection firm? ❒ Yes ❒ No
    If yes, by whom? ____
    List any deficiencies and corrective actions in the past three (3) years:

15. Does the Applicant have a current flood policy in force? If yes, attach a copy of the declarations page. ❒ Yes ❒ No
    If No, would Applicant like a flood quote with your proposal? (Flood quote will be secured through the Write Your Own Flood Program)

16. Does the property have aluminum wiring? ❒ Yes ❒ No

17. Are fire drills conducted regularly under qualified supervision? ❒ Yes ❒ No

SECTION VI – AUTOMOBILE ❒ NA

1. Are all vehicles listed on your auto schedule and/or policy titled to the applicant? ❒ Yes ❒ No

   If no, please explain:

2. Are keys locked and secured away from clients when not in use? ❒ Yes ❒ No
3. Do vehicles with 8 or more seating capacity have an audible backup warning device? ❒ Yes ❒ No
4. Do you require seat belts to be worn by all occupants? ❒ Yes ❒ No
5. Do vehicles equipped for wheelchairs have tie-down belts to stabilize the wheelchair and passengers? ❒ Yes ❒ No
6. Are vehicles checked after passengers disembark to make sure nobody is left behind? ❒ Yes ❒ No
7. Do you transport clients for other human service agencies? If Yes, explain: ❒ Yes ❒ No

8. Are children transported? ❒ Yes ❒ No

   If Yes, do you use a school bus? ❒ Yes ❒ No

   If Yes, does it meet Federal Motor Safety Standards for: ❒ Yes ❒ No

   ❒ Mirrors ❒ Yellow color ❒ Flashing lights ❒ Stop sign arms ❒ Crash survivability

SECTION VII – 15 PASSENGER VANS ❒ NA

1. Are your 15 passenger vans equipped with Electronic Stability Control (ESC)? If no, do you: (check all that apply) ❒ Yes ❒ No

   ❒ Limit passengers to 10 or less ❒ Removed rear seat ❒ Do not allow cargo loaded on roof
2. Is there a pre-trip inspection of the vehicle? ❒ Yes ❒ No

   If Yes, does this include a tire pressure check? ❒ Yes ❒ No

   If no, describe frequency of inspections, tire pressure checks and use of van(s):

3. Are all drivers of 15 passenger vans experienced and trained in the use of this type of vehicle? ❒ Yes ❒ No
4. Is seat belt use enforced in your 15 passenger van(s)? ❒ Yes ❒ No

SECTION VIII – DRIVERS ❒ NA

1. Does the Applicant obtain a written authorization to release driver information from all of staff upon hiring? ❒ Yes ❒ No

   Does the Applicant obtain MVRs on all drivers? ❒ Yes ❒ No If yes, how often? __________

2. What are the Applicant's procedures for dealing with driver accidents or violations?

3. Are all drivers at least 21 years of age? ❒ Yes ❒ No

   How many drivers are over age 65? __________

4. How many drivers (employees and volunteers) aged 21 to 25 transport clients in agency vehicles? _________
5. Do any drivers have a Commercial Driver's License? ❒ Yes ❒ No
6. Explain the Applicant's driver safety program: ____
7. Is training provided for new employees/volunteers prior to their transporting clients? If yes, explain: ❒ Yes ❒ No

8. Does anyone besides employees or volunteers drive the Applicant's vehicles? If yes, explain: ❒ Yes ❒ No

9. Does the Applicant allow personal use of the Applicant's vehicles? If yes, by whom and for what reasons? ❒ Yes ❒ No
10. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following:
    a. More than 2 moving violations and/or accidents within a 3 year period? ❒ Yes ❒ No
    b. Reckless driving, DUI or any felony driving conviction within the past 5 years? ❒ Yes ❒ No
11. Do drivers have the appropriate license(s) for vehicles driven (i.e. buses, heavy trucks, etc.)? ❒ Yes ❒ No
12. Have drivers attended a class or completed a self-study in defensive driving? ❒ Yes ❒ No

SECTION IX – HIRED AND NONOWNED AUTO ❒ NA

1. Are any vehicles leased or hired? ❒ Yes ❒ No

   If Yes, describe what types, what uses and how often:

2. Do you hire from a transportation company? ❒ Yes ❒ No

   If Yes, with drivers? ❒ Yes ❒ No

3. Total number of hired vehicles: _________ Annual cost of hire: ____

   Explain what purpose Employees or Volunteers use their own autos on behalf of the organization?

4. Complete each section below for your employees/volunteers driving their personal vehicles on behalf of the organization:

Usage	Number of Employees Driving Daily/Weekly	Volunteers	Annual MVR's Required?	100/300 Personal Auto Auto Limits Required?
Transporting consumers			❒ Yes ❒ No	❒ Yes ❒ No
Home visits			❒ Yes ❒ No	❒ Yes ❒ No
Meal delivery			❒ Yes ❒ No	❒ Yes ❒ No
Misc. travel			❒ Yes ❒ No	❒ Yes ❒ No

5. Is proof of annual personal auto insurance required for volunteers and employees using their personal automobiles on a regular basis for the organization? ❒ Yes ❒ No

SECTION X – OUTPATIENT/COUNSELING FACILITIES ❒ NA

1. Describe outpatient programs provided:

2. Do you handle clients' money, bills or finances of any type? ❒ Yes ❒ No
   If Yes, explain what is handled and what controls are in place:

3. Do you offer group therapy? ❒ Yes ❒ No
   If Yes, what is average size of group? __________ How often does the group meet per week? __________
   Explain nature of problems treated and/or discussed:

4. Do you operate a crisis hotline? ❒ Yes ❒ No
   Type: ❒ Suicide ❒ Drug/Alcohol ❒ Child/Spouse Abuse ❒ Other: ____
   How many calls annually? _____ Monitored by ❒ Professional ❒ Staff ❒ Volunteers ❒ Other____________________
5. Do you provide adult daycare? If Yes, indicate the number of clients per day: _______ ❒ Yes ❒ No
6. Do you provide respite care programs? If Yes, maximum number of consecutive days service is offered: ____ ❒ Yes ❒ No
   Describe respite care program (i.e. ages taken, specialization, disabilities served, etc):

   a. Can parents or caretakers meet with and interview the people who will be providing the care? ❒ Yes ❒ No
   b. Do you maintain records of respite care services provided? ❒ Yes ❒ No
6. Are childcare services available for the children of your counseling patients? ❒ Yes ❒ No
   Average number of children: __________ Number of staff: __________ Hours of operation: __________
   (If Full-time Day Care, complete Day Care supplemental application)
7. Do you operate a meal delivery service? ❒ Yes ❒ No
   If Yes, number of meals annually: _____________ Do you charge a fee for the meals? ❒ Yes ❒ No
   If Yes, what is the total revenue? $________________________
8. Annual number of clients by age group: Less than18: ______ 18-35: ______ 36-65: ______ Over 65: ______
9. Explain screening procedures for clients:

10. Are children's services available for the children of the Applicant's counseling patients? ❒ Yes ❒ No
11. Average number of children: _____ Number of staff: _____ Hours of operation: _____

SECTION XI – COOKING FACILITIES ❒ NA

1. The cooking equipment is: ❒ Electric ❒ Gas ❒ Propane ❒ Other____
2. The cooking equipment is located in: ❒ One common area ❒ Each floor ❒ Individual Rooms
   ❒ Other____ ❒ Total number of cooking areas_ _____________
3. Who has access to the cooking area? (check all that apply) ❒ Staff ❒ Clients/Residents ❒ Volunteers ❒ Visitors/Public
4. For whom is food prepared? (check all that apply) ❒ Staff ❒ Clients/Residents ❒ Volunteers ❒ Visitors/Public
5. The cooking equipment type is: ❒ Residential ❒ Commercial
   If commercial type, complete the following section:
   a. Describe Equipment: (Grills, broilers, fryers, etc) and number of each:

   b. Cooking Equipment is equipped with: ❒ Hoods ❒ Ducts ❒ Exhaust Fans ❒ Automatic fire suppression systems
      ❒ Automatic fuel shutoff controls ❒ No protection ❒ Other____
   c. Is there a cleaning maintenance contract for the fire extinguishing system? ❒ Yes ❒ No
      Cleaned by: ❒ Applicant ❒ Cleaning contractor
      If Yes, what is the frequency of the cleaning?____
      And, what is the name of the maintenance company?____
      Is the system UL 300/NFPA compliant? ❒ Yes ❒ No
   d. Are the duct, hood and filter cleaned regularly? ❒ Yes ❒ No
6. Do any staff members supervise the cooking area? ❒ Yes ❒ No
7. Are there fire extinguishers in the cooking area(s)? ❒ Yes ❒ No

SECTION XII – IN-HOME SERVICES ❒ NA

1. Services Provided (check all that apply):

❒ Nursing care	❒ Speech therapy	❒ Social Work	❒ Nutrition counseling
❒ Bathing	❒ Changing catheters	❒ Dressing	❒ Meal preparation
❒ Laundry	❒ Running errands	❒ Housecleaning	❒ Medication management
❒ Eating	❒ Restroom aid	❒ Repositioning	❒ Transporting to/from appts
❒ Blood testing	❒ Infusion therapy	❒ Other:	

2. How many employees provide in-home services? ___________________________ Volunteers? ____________________
3. Number of non-ambulatory clients? _________________
4. Payroll for the last 12 months for in-home services: $_______________________
5. Do you sell and/or rent medical equipment? ❒ Yes ❒ No
   If Yes, what are annual sales? $____________________________ Annual rental receipts? $_______________________
6. Is all staff informed of AIDS/HIV patients ❒ Yes ❒ No
7. Do you have written procedures in place to prevent theft from the clients' homes? ❒ Yes ❒ No
8. Are medications administered? ❒ Yes ❒ No
9. Is each visit documented? ❒ Yes ❒ No
10. Explain how staff is monitored with regard to providing in-home services:

SECTION XIII – FOOD BANK ❐ NA

1. Are aisles kept clear and unobstructed? ❐ Yes ❐ No
2. Are goods properly stored and stacked? ❐ Yes ❐ No
3. Are any goods kept outdoors? If Yes, explain: ❐ Yes ❐ No

4. Are forklift operators properly trained and supervised? ❐ Yes ❐ No
5. Does the Applicant provide pick up services? ❐ Yes ❐ No
6. How many drop off containers and/or pick up containers does the Applicant have? ___________________________________
7. Does the Applicant pick up from homes or businesses? ❐ Yes ❐ No
8. What radius does the Applicant drive? ____
9. Does the Applicant have a loading dock or appropriate place to unload goods? ❐ Yes ❐ No
10. How often are incoming goods sorted to identify spoiled and/or hazardous goods? ___________________________________
11. Are unwanted goods disposed of promptly and properly? ❐ Yes ❐ No
12. If food bank, are product expiration dates monitored? ❐ Yes ❐ No
13. Do you provide pick-up services? If Yes, what radius do you drive?____________ ❐ Yes ❐ No
14. How many drop off and/or pick up containers do you have? ____
15. Do you have a loading dock or appropriate place to unload goods? ❐ Yes ❐ No
16. Is there a system in place to adequately document all goods? ❐ Yes ❐ No
17. Are expiration dates checked on all items? ❐ Yes ❐ No
18. How are unwanted goods identified and disposed of?____
19. Is re-stocking done during customer shopping hours? ❐ Yes ❐ No
    If Yes, are those areas off-limits during stocking? ❐ Yes ❐ No
20. Are parking lots and customer walk and loading areas well-maintained and well-lighted? ❐ Yes ❐ No
21. Are empty wood pallets stored in areas away from warehoused goods? ❐ Yes ❐ No
22. Is there sufficient space in the aisles to allow for fire control and firefighter access and easy movement of goods? ❐ Yes ❐ No

SECTION XIV – PLAYGROUND ❐ NA

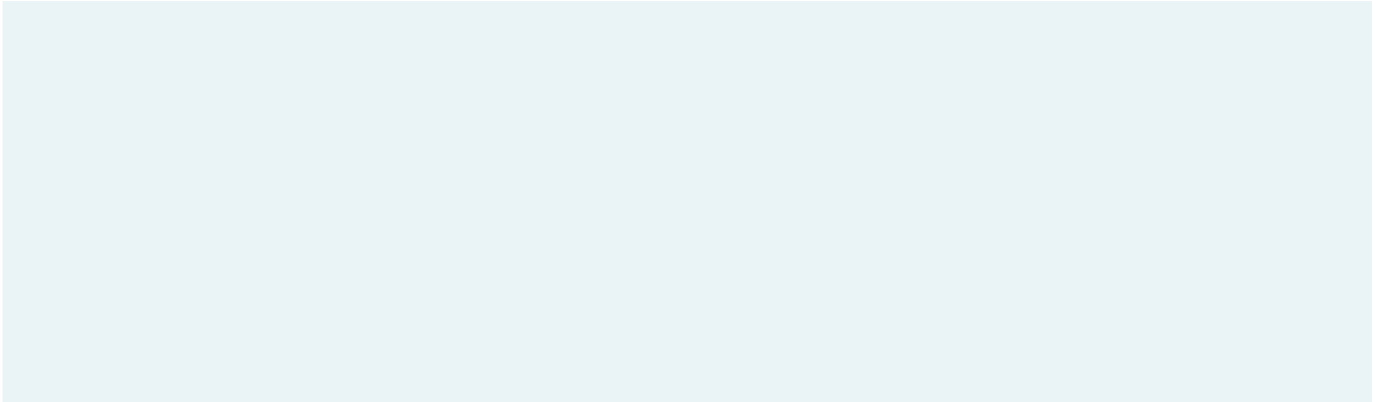
1. Is the playground area supervised while in use? ❐ Yes ❐ No
2. Who uses the area? ❐ Clients/Residents ❐ Visitors/Public ❐ Staff
3. Is the play area fenced? ❐ Yes ❐ No
4. Describe all equipment including the maximum height of the equipment:

5. Describe surface under the playground equipment:

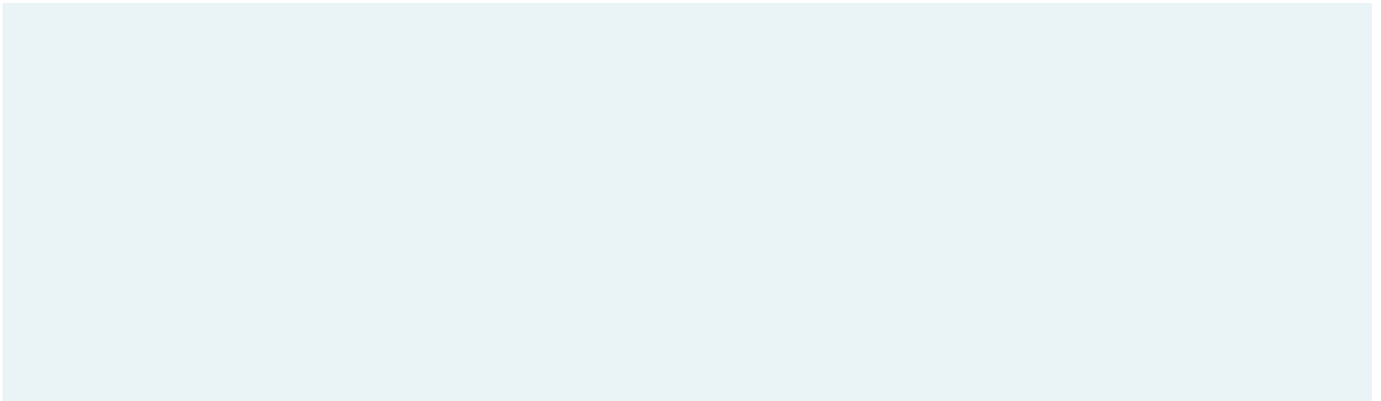
6. Is the playground equipment properly inspected? If Yes, how often? _________________________ ❐ Yes ❐ No

SECTION XV – FITNESS AREA ❒ NA

1. Is the fitness area supervised during all open hours? ❒ Yes ❒ No
2. Is it open at any time when the Applicant's facility is closed? If yes, when and why? ❒ Yes ❒ No



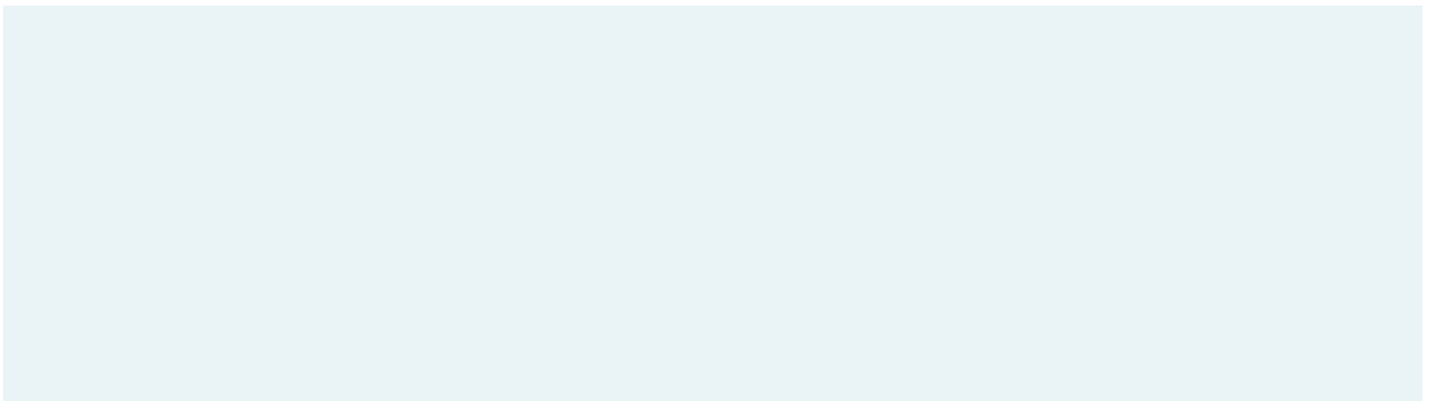
3. Who uses the area? ❒ Staff ❒ Clients/Residents ❒ Visitors/Public
4. Describe all fitness equipment and facilities (both indoor and outdoor):



5. How often and by whom is the equipment and area inspected? ____
6. Does the Applicant keep logs of users? ❒ Yes ❒ No
7. Does the Applicant require hold harmless/waivers to be signed by all users? ❒ Yes ❒ No

SECTION XVI – KEY EMPLOYEE

If Key Employee coverage is requested, provide name(s) and position(s):



SECTION XVII – BENEFIT'S GROUP CENSUS ❒ NA

Group Name:	
Avg. Number of EE’s:	
Address:	
Nature of Business/SIC:	
Group Contact:	
Phone:	
Fax:	
Email:	
Tax ID:	

Employee ID	Member Class	Last Name	First Name	Home Zip Code	Age / Date of Birth	Gender	Employment Status

SECTION XVII – BENEFIT'S GROUP CENSUS ❐ NA

Salary	Date of Hire	Medical Election	Medical Tier	Dental Election	Dental Tier	Vision Election	Vision Tier	Work Zip Code

COMMENTS

DECLARATION AND SIGNATURE

Authorized Entity Representative Designation

The person named herein is authorized and designated to give and receive any and all notices on behalf of the entity and all Insureds from the entity or their authorized representative(s) concerning this insurance.

Named Individual:____

Title/Position:____ **Date:** _______________________________

Attestation

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

Signature of Authorized: ____

Entity Representative: ____ **Date:** ______________________________

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MEALS on WHEELS
AMERICA

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