



Allied World Insurance Company ("Insurer")

All questions must be answered and the application must be dated and signed before a quotation is given.

Return and make checks payable to: American Professional Agency, Inc. 95 Broadway, Amityville, NY 11701 (631) 691-6400 • (800) 421-6694

KANSAS APPLICATION FOR SOCIAL SERVICE AGENCY PROFESSIONAL LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

Notice to Florida Applicants: License #054346502 issued to Richard C. Imbert

Notice to Iowa Applicants: License # IA 0000000107776 issued to Richard C. Imbert

Notice to California Applicants: License #0555091 issued to American Professional Agency, Inc.

THIS APPLICATION IS FOR COVERAGE TYPE: [ ] CLAIMS-MADE [ ] OCCURRENCE-BASED

NOTICE; THE COVERAGE OF A CLAIMS-MADE POLICY IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED OR PROCEEDING FIRST BROUGHT DURING THE POLICY PERIOD, AND REPORTED IN WRITING TO THE INSURER IN ACCORDANCE WITH THE TERMS OF THE POLICY. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR LEGAL OR INSURANCE ADVISOR.

NOTICE: A SMALLER LIMIT APPLIES WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT. (SEE SECTION V. (C) MAXIMUM LIMITS OF LIABILITY "SEXUAL MISCONDUCT" IN THE POLICY)

SUPPLEMENTAL APPLICATIONS

If you are providing any of the following services or are requesting additional coverages, please complete the respective supplemental applications and submit with this application.

- SERVICES: [ ] Inpatient/Residential Treatment Supplemental Application [ ] Methadone Treatment Supplemental Application [ ] Addiction Services Supplemental Application

- ADDITIONAL COVERAGES: [ ] Employment Practices Liability Defense Only (EPL) Supplemental Application [ ] General Liability ( GL) Supplemental Application

GENERAL INFORMATION

1. Name of Applicant: \_\_\_\_\_ Address: \_\_\_\_\_ (City) (County) (State) (Zip Code) (If more than one location list on separate sheet and attach to application.)

Person to Contact: \_\_\_\_\_

Business Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Email: \_\_\_\_\_

# Social Service Agency Application (continued)

2. Applicant is a:  For Profit Corporation  Non-Profit Corporation  
 Partnership  Municipal/Governmental  
 Other (specify) \_\_\_\_\_

3. (a) Limits of Liability desired (check one):

(Limits of Liability apply to each claim. A series of continuous, repeated or interrelated wrongful acts are considered one wrongful act and one claim.)

The first limit is applicable to each claim. The second limit is the annual aggregate the Insurer is liable for.

- \$100,000/300,000  \$1,000,000/1,000,000  \$1,000,000/3,000,000  \$2,000,000/4,000,000  
 \$1,000,000/4,000,000  \$1,000,000/5,000,000  \$2,000,000/2,000,000

- (b) Defense Costs Related to Proceedings:

Defense costs of licensing board investigations or proceedings are covered by the policy for a limit of \$35,000 for no charge. If additional limits (for a charge) are needed, please select below

- \$50,000  
 \$75,000  
 \$100,000  
 \$125,000  
 \$150,000

- (c) Effective Date requested: \_\_\_/\_\_\_/\_\_\_ Retroactive date (for claims-made coverage): \_\_\_/\_\_\_/\_\_\_

4. List the name and information for every employee including clerical. If additional space is needed, please use a separate sheet of paper. Independent Contractors are not to be listed since they are not personally protected.

Name	Degree & Field of Study	Licensed As	Certified As	Full Time Part Time	Position Held (Job Title)

5. Does the agency utilize the services of any Independent Contractors or Consultants (1099 form)?  Yes  No

If yes, on a separate sheet of paper, please provide us with all their names, degrees and fields of study

6. Total number of hours donated by volunteers in an average work week: \_\_\_\_\_

7. Average number of students working for, or training under, the direction of the applicant named in Question 1: \_\_\_\_\_

8. The applicant is a member of (check next to those which apply):

- Council on Accreditation of Services for Families and Children  
 Child Welfare League of America  
 United Way  
 Other (specify): \_\_\_\_\_

9. A) The agency is licensed by state or local authorities:  Yes  No

If yes, indicate which authority: \_\_\_\_\_

B) The agency is certified by: \_\_\_\_\_

10. Year established: \_\_\_\_\_

11. In the past five years, has the applicant sold or divested itself of any facilities, subsidiaries or assets, or discontinued any of its operations?  Yes  No

If "Yes," describe: \_\_\_\_\_

# Social Service Agency Application (continued)

12. Indicate Gross Revenues/Annual Receipts

A) Last Calendar Year: \_\_\_\_\_ B) This Calendar Year: \_\_\_\_\_

13. Give a complete description of the services provided. If additional space is required, attach a separate sheet to this application. (Include any descriptive material and/or brochures.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Does the applicant conduct or provide any services via the Internet?  Yes  No

If "yes," describe services: \_\_\_\_\_

\_\_\_\_\_

15. Are there any camp, adventure/wilderness, ropes course or any type of recreational programs offered?  Yes  No

If "Yes," describe and submit brochure or detailed narrative of activities: \_\_\_\_\_

\_\_\_\_\_

**ALL PARTS OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.  
If additional space is required, attach a separate sheet to this application**

## ADOPTION SERVICES

16. Does the applicant provide adoption services?  Yes  No

A. Number of adoptions arranged in last calendar year: \_\_\_\_\_

B. Estimate number of adoptions you will arrange this calendar year: \_\_\_\_\_

C. What are the ages of the children placed for adoption? \_\_\_\_\_

D. Outline the protocol used in the adoption procedure: \_\_\_\_\_

E. Does the applicant have legal custody of children?  Yes  No

F. Is a guardian appointed to each child to ensure the child's welfare?  Yes  No

## FOSTER CARE

17. Does the applicant place children in foster homes?  Yes  No

A. Number of children placed in foster homes during the last calendar year: \_\_\_\_\_

B. Estimate the number of children you will place in foster homes this calendar year: \_\_\_\_\_

C. What are the ages of the children placed in foster homes? \_\_\_\_\_

D. How many foster homes does the applicant utilize? \_\_\_\_\_

E. Are all homes licensed by applicable state and/or local authorities?  Yes  No

F. How does the applicant obtain foster homes? \_\_\_\_\_

G. Who licenses the foster homes? \_\_\_\_\_

\_\_\_\_\_

# Social Service Agency Application (continued)

H. Does the applicant certify the foster homes it utilizes?  Yes  No

If yes, describe standards set for certification: \_\_\_\_\_  
\_\_\_\_\_

I. What is the applicant's criteria upon which a foster home is rated and accepted? \_\_\_\_\_  
\_\_\_\_\_

J. How often are children moved from one foster home to another? \_\_\_\_\_  
\_\_\_\_\_

K. How many times does the applicant have its employees visit the children in the foster homes?  
\_\_\_\_\_

L. Who compensates foster parents? \_\_\_\_\_

M. Does the applicant require proof of Foster Parents Liability Insurance?  Yes  No

N. Please forward proof of General Liability insurance indicating minimum of \$100,000/\$300,000 coverage.

O. What is the procedure utilized by the applicant to handle allegations of child abuse (sexual and other) in the foster home? \_\_\_\_\_  
\_\_\_\_\_

## RESIDENTIAL CARE

18. Does the applicant provide residential care services?  Yes  No

***If "Yes," please complete Inpatient/Residential Supplemental Application***

## OUTPATIENT BEHAVIORAL CARE SERVICES

19. Does the applicant provide outpatient counseling services only?  Yes  No

20. Does the applicant provide outpatient and in-patient counseling services?  Yes  No

***If "Yes," please complete Inpatient/Residential Supplemental Application***

21. The applicant provides (check next to those that apply):

- Mental Health / Behavioral Counseling
- Alcohol / Drug Rehab (**please also complete Addiction Services Supplemental Application**)
- Methadone Treatment (**please also complete Methadone Treatment Supplement Application**)
- Other (describe): \_\_\_\_\_

22. (a) Number of annual outpatient or client visits last calendar year: \_\_\_\_\_

(b) Estimate the number of annual outpatient or client visits during this calendar year: \_\_\_\_\_

23. Number of clients per day:

A. Adult Day Care: \_\_\_\_\_

B. Child Day Care: \_\_\_\_\_

C. Sheltered Workshops: \_\_\_\_\_

24. What types of problems are treated by the applicant? \_\_\_\_\_  
\_\_\_\_\_

## Social Service Agency Application (continued)

25. Does the applicant have services specifically concerned with sexual response/dysfunction?  Yes  No  
If yes, does the agency utilize any sexual surrogates and/or hands on therapy when delivering these services?  Yes  No  
Please explain: \_\_\_\_\_  
\_\_\_\_\_
26. Does the applicant perform any research activities?  Yes  No  
If yes, give full particulars: \_\_\_\_\_  
\_\_\_\_\_
27. Does the applicant maintain any facilities for detoxification of substance abuse?  Yes  No  
If yes, give full particulars: \_\_\_\_\_  
\_\_\_\_\_
28. If the applicant provides group therapy sessions, answer the following:  
i. Average size of group: \_\_\_\_\_  
ii. Average number of times a week the group meets: \_\_\_\_\_  
iii. Indicate the classes for whom group therapy is used: \_\_\_\_\_  
\_\_\_\_\_
29. Does the applicant provide hotline services? If yes, answer the following:  Yes  No  
i. Number of calls (annually): \_\_\_\_\_  
ii. What types of problems are handled by the hotline? \_\_\_\_\_  
iii. Do you use volunteers as counselors?  Yes  No  
iv. If volunteers are used as counselors, outline the training they receive: \_\_\_\_\_  
\_\_\_\_\_  
v. Hours of operation of the hotline: \_\_\_\_\_  
Please provide us with a written protocol outlining the procedure for handling all calls.

### RESETTLEMENT SERVICES

30. Does the applicant provide resettlement services?  Yes  No
31. Please provide a copy of all the services provided by your agency including such information as protocol used for an unaccompanied minor; policy regarding periodic evaluation of foster homes, group homes, and residential care centers; procedures regarding the handling of alleged abuse of any kind.
32. Does the agency accept responsibility for the local resettlement of clients of a national voluntary agency? If yes, please provide us with the written agreement which describes the relationship between the agencies and the services provided.  Yes  No

### CURRENT/PRIOR PROFESSIONAL LIABILITY INSURANCE COVERAGE

33. List the expiration date of current/prior Professional Liability Insurance carried: \_\_\_\_\_  
Prior limits: \_\_\_\_\_ Prior premium: \_\_\_\_\_  
Prior insurance carrier: \_\_\_\_\_  
Policy type:  Claims Made Retroactive date: \_\_\_\_\_  Occurrence

# Social Service Agency Application (continued)

## REPRESENTATION SECTION

Any policy issued by the Company is based on the following Representations.

34. After inquiry\* of each individual listed in Question 4:

**\*NOTE: "After inquiry" means that the Applicant has inquired of each person as to whether he/she has information pertinent to this question. If you answer "Yes," please include all documents pertinent to the situation you are describing.**

- A. Has any person named in Question 4, , ever been convicted of a crime in any state or country?  Yes  No

If yes, please give full particulars in order for your Application to be considered: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- B. Has any person named in Question 4, ever had any licensing board or professional ethics body require the surrender of a license or found any such person guilty of a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?  Yes  No

If yes, please give full particulars and provide copies of charges, correspondence and any findings in order for your Application to be considered: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- C. Are there any complaints, charges, or investigations pending against any person named in Question 4 by a licensing board or professional ethics body for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?  Yes  No

If yes, please give full particulars and copies of charges, correspondence and any findings in order for your Application to be considered: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### NOTE: MISSOURI APPLICANTS DO NOT RESPOND TO QUESTION 34D

- D. Has the Applicant named in Question 1 or any person named in Question 4, ever had any insurance company or Lloyd's decline, cancel, refuse to renew, or accept only on special terms any professional liability insurance?  Yes  No

If yes, please give full particulars in order for your Application to be considered: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- E. Has any professional liability claim or suit ever been made against the Applicant named in Question 1, its directors, officers, or any person named in Question 4, their predecessors in business or against any past or present partner(s)?  Yes  No

If yes, please give full particulars and copies of any summons and complaints, pertinent correspondence and outcome, if any, in order for your Application to be considered: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- F. Are there any circumstances, including any loss of private or confidential information, of which the Applicant named in Question 1, its officers or directors or any person named in Question 4, is aware of that may result in any professional liability claim or suit being made against any person named in Question 4, their predecessors in business or against any past or present partner(s)?  Yes  No

If yes, please give full particulars in order for your Application to be considered: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# Social Service Agency Application (continued)

- G. Is any person named in Question 4, , engaged in or ever been engaged in any sexual misconduct\* with any current or former patients or any current or former patient's spouse or any person with a direct relationship to the current or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)?  Yes  No

(\*Sexual misconduct means any actual or alleged erotic physical contact or attempt, threat or proposal thereof.)

If yes, please give full particulars in order for your Application to be considered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- H. Has any person named in Question 4, ever had any hospital restrict or revoke privileges or invoke probation for any cause?  Yes  No

If yes, please give full particulars in order for your Application to be considered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- I. Has the Applicant named in Question 1 or any person named in Question 4,, ever been suspended, restricted, or put on probation by any governmental health programs (e.g. Medicare or Medicaid)?  Yes  No

If yes, please give full particulars in order for your Application to be considered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- J. Is any person named in Question 4 currently being, or ever been, treated for a serious health problem that did or can impair the ability to treat patients?  Yes  No

If yes, please give full particulars in order for your Application to be considered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## NOTICES TO APPLICANT & FRAUD WARNINGS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

**NOTICE TO ALABAMA 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 RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF."

**NOTICE TO ARKANSAS 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

## Social Service Agency Application (continued)

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

**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 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, 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 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



# Social Service Agency Application (continued)

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 RHODE ISLAND 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 TENNESSEE 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 TEXAS APPLICANTS:** “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.”

**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.”

**NOTICE TO VIRGINIA 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 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 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 ALL OTHER APPLICANTS:** “IT IS A CRIME FOR ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS CAUSES TO BE PRESENTED OR PREPARES WITH 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 FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.”


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## DECLARATION AND SIGNATURE

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
(APPLICANT/OWNER/PRESIDENT OF CORPORATION)

Title: \_\_\_\_\_

Signature of Authorized Representative of the American Professional Agency, Inc.  \_\_\_\_\_

*This application does not bind the Applicant nor the Company to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued. Application must be signed, dated and fully completed to be considered for quotation.*

Please mail to Program Administrator:

**American Professional Agency, Inc.**  
**95 Broadway, Amityville, NY 11701**  
**(631) 691-6400 • (800) 421-6694**

# Social Service Agency Application (continued)



www.americanprofessional.com

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## ELECTRONIC SELECTION/ REJECTION OPTION FORM

### ELECTRONIC SELECTION / REJECTION OPTION FORM

Kansas law requires the Insurer to obtain consent from insureds prior to engaging in any electronic delivery of insurance policies and/or other supporting documents in connection with the policy. You have the right to:

- Select electronic delivery;
- Select electronic delivery and paper delivery;
- Reject electronic delivery;
- Withdraw your consent if you decide you no longer want to receive electronic delivery of your insurance policy and/or other supporting documents in connection with your insurance policy.

**SELECTION OF ELECTRONIC INSURANCE POLICY DELIVERY OPTION**

I select the option to receive the following documents in connection with my insurance policy electronically, for myself and all those covered under the policy. I acknowledge I may no longer receive paper copies of my insurance policy, unless I advise my insurer to continue to provide paper copies in addition to electronic copies.

Insurance Policy

Identification Card

Notices of Cancellation

Notices of Nonrenewal

Other supporting documents in connection with my insurance policy

**SELECTION OF ELECTRONIC DELIVERY AND PAPER DELIVERY OPTION**

I select the option to receive both electronic and paper copies of my insurance policy and/or other supporting documents in connection with my insurance policy, for myself and all those covered under the policy

**REJECTION OF ELECTRONIC DELIVERY OPTION**

I reject the option to receive my insurance policy and/or other supporting documents in connection with my insurance policy electronically, for myself and all those covered under the policy. I will continue to receive paper copies of such documents.

**WITHDRAWAL OF CONSENT OF ELECTRONIC DELIVERY**

I withdraw my previous consent of electronic delivery of my insurance policy and/or other supporting documents in connection with my insurance policy, for myself and all those covered under the policy. I elect to receive paper copies of such documents in the future.

# Social Service Agency Application (continued)

## ELECTRONIC DELIVERY DISCLOSURE

The policyholder who elects to allow for insurance policy and/or other supporting documents in connection with the insurance policy to be sent to the electronic mail address provided should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
(APPLICANT/OWNER/PRESIDENT OF CORPORATION)

Title: \_\_\_\_\_