
Public Entity Application

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Applicant Name:

General Information

Applicant Name, as to be shown on policy:

Risk Manager Contact/Title:

Address:

Street

City

State

Zip

County

Phone:

Website URL:

Broker Name:

Contact/Title:

Address:

Street

City

State

Zip

County

Phone:

Website URL:

Surplus Lines Details / FEIN No.:

Retail Broker Commission Fee:

Proposed Effective Date:

Quote Need By Date:

1. Is a full-time risk manager employed? Yes No

2. What is the Bond Rating of The Entity? Moody's:
Standard & Poor's:

3. Has any insurance for The Entity been canceled or non-renewed in the last five (5) years? Yes No

If yes, please explain:

4. How will claims be handled? In-House Independent Administrator/Adjuster Insurance Company

If you selected In-House of Independent Administrator/Adjuster, the TPA Section must be completed.

Loss Control Information

Please describe or attach information regarding risk management programs, training programs, and/or safety programs.

1. Is a full-time safety/loss control person employed? Yes No

If yes, please describe duties:

2. Do you have any formal written loss control programs in place regarding the third party exposures listed below?

A. School Board Liability	<input type="checkbox"/> Yes <input type="checkbox"/> No	E. Vehicles / Fleet	<input type="checkbox"/> Yes <input type="checkbox"/> No
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B. Contractual Liability	<input type="checkbox"/> Yes <input type="checkbox"/> No	F. Campus Housing	<input type="checkbox"/> Yes <input type="checkbox"/> No
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C. Peer Harassment	<input type="checkbox"/> Yes <input type="checkbox"/> No	G. Athletic Programs	<input type="checkbox"/> Yes <input type="checkbox"/> No
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D. Employment Related Practices	<input type="checkbox"/> Yes <input type="checkbox"/> No
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3. Please describe or attach the procedures utilized to administer all loss control efforts for item 2, A-G.

Applicant Name:

Loss Control Information – Cont.

4.	Are independent contractors utilized?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe when & for what purposes:		
5.	Are Certificates of Insurance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, state minimum limits required:		
6.	Do you incorporate the effectiveness of loss control efforts into the performance evaluation for administrators, department heads, supervisors and managers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you have an internal claim and loss costs analysis system which can be used to prompt necessary loss control program changes on a timely basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant Name:

Coverages

Current Coverages & Limits								
	Claims Made / Occurrence	Limit	Deductible / SIR	Annual Aggregate	Maintenance Deductibles	Retroactive Date	Expiring Carrier	Expiring Premium
Property		\$	\$		\$			\$
Property Flood		\$	\$	\$	\$			
Property Named Wind		\$	\$		\$			
Property Earthquake		\$	\$	\$	\$			
Auto Physical Damage		\$	\$		\$			\$
General Liability		\$	\$	\$				\$
Law Enforcement Liability		\$	\$	\$				\$
Automobile Liability		\$	\$	\$				\$
E&O / EPLI		\$	\$	\$	\$			\$
Sexual Harassment		\$	\$	\$	\$			
Sexual Abuse		\$	\$	\$	\$			
Employee Benefits Liability		\$	\$	\$				\$
Workers' Compensation & Employer's Liability		\$	\$					\$
Crime		\$	\$		\$			\$
Umbrella / Excess Liability		\$	\$	\$	\$			\$

Desired Coverages & Limits						
	Claims Made / Occurrence	Limit	Deductible / SIR	Annual Aggregate	Maintenance Deductibles	Retroactive Date
Property		\$	\$		\$	
Property Flood		\$	\$	\$	\$	
Property Named Wind		\$	\$		\$	
Property Earthquake		\$	\$	\$	\$	
Auto Physical Damage		\$	\$		\$	
General Liability		\$	\$	\$		
Law Enforcement Liability		\$	\$	\$		
Automobile Liability		\$	\$	\$		
E&O / EPLI		\$	\$	\$	\$	
EPL Sexual Harassment		\$	\$	\$	\$	
EPL Sexual Abuse		\$	\$	\$	\$	
Employee Benefits Liability		\$	\$	\$		
Workers' Compensation & Employer's Liability		\$	\$			
Crime		\$	\$		\$	

Applicant Name:

Exposure Summary

Property – Please attach up-to-date Schedule of Values	
Total Insured Values:	Total Insured Values in Flood Zone A:
Number of Locations:	Total Insured Values in Flood Zone V:
ACV Vehicles:	RCV Vehicles:

General Liability		
Please provide the following if available: Most recent audited financial statements, most recent budget, & most recent actuarial study.		
Population: _____		
Miles of Streets / Roads: _____		
Total Revenue: _____		
Gross Operating Expenditures: _____		
Net Operating Expenditures:		<i>Complete Net Operating Section, pg.</i>
Number of Employees:	Full-Time:	Part-Time:
Utilities (indicate payroll excluding clerical):	Water: \$	<i>Complete Section on pg.</i>
	Sewage: \$	<i>Complete Section on pg.</i>
	Electric: \$	<i>Complete Section on pg.</i>
	Gas: \$	<i>Complete Section on pg.</i>
Housing Projects:	Number of Locations:	Number of Units:
Swimming Pools:	Number of Pools:	
	Number of Pools with Lifeguards:	
	Number of Water Parks:	
	Number of Diving Boards:	
Stadiums (5K+ Capacity):	Seating Capacity:	
	Annual Receipts: \$	
Exhibition / Convention Center:	Capacity:	Square Footage:
Principal Uses:		
Special Events:	Are Certificates of Insurance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are Hold Harmless Agreements from vendors obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amusement Parks:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number: _____
Ski Facilities:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number: _____
Golf Courses:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number of courses: _____
Watercraft:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe: _____
Lakes / Reservoirs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe: _____
Dams / Levees:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number: _____ <i>Complete Section on pg.</i>
Beaches:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number: _____
Zoos:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number: _____
Parks:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number: _____
Athletic Participants:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number: _____

Applicant Name:

Exposure Summary – cont.

Incidental Medical Malpractice – Please complete section on pg.			
Physicians:	Full-Time:	Part-Time:	Volunteers:
Nurses:	Full-Time:	Part-Time:	Volunteers:
EMTs & Paramedics:			

Law Enforcement Liability – Please complete section on pg.		
Police Officers:	Full-Time, Armed:	Full-Time, Non-Armed:
	Part-Time, Armed:	Part-Time, Non-Armed:
	Volunteers:	
Jail Capacity:	Number of Holding Cells:	Number of Detention Cells:

Automobile Liability	
Private Passenger:	
Police Cars:	
Fire Trucks:	
Vans (no passengers), Light Trucks, Pickups up to 10K lbs. GVW:	
Medium Trucks:	
Heavy Trucks:	
Fire Trucks:	
Ambulances:	
Buses:	Capacity 1-8:
	Capacity 9-20:
	Capacity 21-60:
	Capacity 61+:

Applicant Name:

Historical Data

Please provide year-end financial & exposure information for the past five years:

Year	Total Revenue	Gross Operating Expenditure	Net Operating Expenditure	Accumulated Deficit / Surplus	Population	No. of Police	No. of Vehicles	Payroll	No. of Employees
Current									
1 st Prior									
2 nd Prior									
3 rd Prior									
4 th Prior									

Applicant Name:

Property Total Insurable Values

Please attach up-to-date Schedule of Values

Total All Buildings:	\$
Total All Contents:	\$
Business Interruption:	\$
Extra Expense:	\$
Loss of Rents:	\$
Tuition Fees:	\$
Owned Builders' Risk:	\$
Property in Transit:	\$
Accounts Receivable:	\$
Valuable Papers & Records:	\$
Fine Arts:	\$
Mobile Equipment:	\$
EDP Equipment:	\$
EDP Media:	\$
Auto Physical Damage:	\$
Underground Property: (Provide details separately)	\$
Garage Keeper's Legal Liability:	\$
Miscellaneous, Please Specify Below:	
	\$
	\$
	\$
	\$
	\$
	\$
Total Insurable Values:	\$

Incidental Medical Malpractice

1.	Does the physician, nurse or other healthcare provider carry E&O Professional Medical Malpractice Coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	A. Number of Medical Clinics:		
	B. Are there operations performed other than out-patient services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, please describe specifically:		
	C. Does The Entity purchase separate insurance for these facilities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, please list all carriers and limits:		
	If no, does The Entity contract out medical services for these facilities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Applicant Name:

Net Operating Expenditures

1.	Total Operating Expenditures:		\$
2.	Deductions:	A. Capital Improvements (<i>any purchase or improvement of any individual item of personal or real property which is bonded or financed</i>):	\$
		B. Expenditure for independent Contractor Operations (<i>where contractor carries adequate insurance</i>):	\$
		C. Welfare Benefits (<i>not administrative costs</i>):	\$
		D. Expenditures on Exposures which are separately rated below:	
		EMTs / Nurses / Paramedics:	\$
		Housing Projects:	\$
		Law Enforcement Liability:	\$
		Schools or Colleges:	\$
		Streets / Highways / Roads:	\$
		Utilities:	\$
3.	Total Net Operating Expenditures:		\$

Automobile Liability

1.	How often are vehicles inspected?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly
2.	Are safety inspection records maintained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3.	Do you have a formal written accident reporting procedure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
4.	Do you have driver-hiring criteria in place?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	A. MVRs checked on all drivers prior to hire?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	B. MVRs checked at least annually thereafter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	C. Drug / alcohol testing at time of hire?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	D. Reference checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	E. Road test given prior to hire?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
5.	Do you provide a driver training program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	If yes, please describe:				
	Any other actions taken with regard to driver hiring or training?				
6.	Do you provide safety incentive awards?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	If yes, please describe:				
7.	Are employees, or families of employees, allowed to use company autos for non-business/personal use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	If yes, please describe:				

Applicant Name:

Law Enforcement

1.	Is your department accredited by The Commission on Accreditation for Law Enforcement Agencies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Do all officers meet state certifying agency minimum training standards?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Describe the relationship with The Entity's Risk Manager and key department heads (i.e. police chief):		
4.	Do you contract law enforcement to any public or private entry?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Are you part of any mutual law enforcement agreements between political subdivisions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Do all Officers Receive:		
	Firearms Training and Qualification	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Frequency of qualification per year?		
	Impact Weapon Training and Certification	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Chemical Agent (Oleresincapsium) Training and Certification	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Taser Training and Certification	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	High Speed Pursuit Driving Training	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Department Policy and Procedure Training	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Constitutional Use of Force Training	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Does the department have a policy and procedure manual?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Date of last overall revision of your policy and procedure manual:		
	Is the manual and subsequent revisions reviewed with and distributed to all personnel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are employees required to sign-off?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have the policies and procedures been reviewed by legal counsel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, names of counsel:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Does this department have written policies governing the following:		
	Use of Force	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Firearms and Less than Lethal Weapons	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hot Pursuit	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sexual Harassment	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Jail Operation

1.	Date of last inspection by state or federal corrections officials? <i>The most recent copy of your state or federal department of corrections report is required.</i>		
2.	Year Facility was Built:	Year Renovated:	
3.	What is state certified capacity or facility?		
4.	What is the average number of daily inmates?		
5.	What is the average length of stay?		
6.	In the last five years, have there been any suicide attempts resulting in death or serious injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<i>Please provide details of each incident and attach your suicide prevention policy.</i>		
7.	Are jailers on premise at all times?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Are walk-throughs at the facility done every 30 minutes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Date of last inspection by Fire Inspector?		
10.	Do you have smoke detectors in jail?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Applicant Name:

Jail Operation – Cont.

11.	Are there Audio / Video Systems In:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Book Areas? Audio: <input type="checkbox"/> Yes <input type="checkbox"/> No	Video: <input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sally Port? Audio: <input type="checkbox"/> Yes <input type="checkbox"/> No	Video: <input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cell Area? Audio: <input type="checkbox"/> Yes <input type="checkbox"/> No	Video: <input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Do the Jail Operations Manual Include: <i>Please attach policies on items A-E.</i>		
	A. Intake Screening and Classification of Inmates? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Updated:	
	B. Strip Searches? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Updated:	
	C. Jail Evacuations? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Updated:	
	D. Medical Treatment / Sick Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Updated:	
	E. Suicide I.D. Guidelines and Preventions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Updated:	
13.	Are men and women segregated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Are youthful offenders (aged 18 & younger) separated from older inmates?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Are prisoners who have committed violent crimes kept separate from those who have been incarcerated for lesser offences?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	Is jail under a court order of consent decree? <i>(If yes, attach copy with any modifications)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Public Officials Liability

1.	Do you have a written human resources manual?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what year was this manual last updated?		
	Please indicate if the manual contains a policy / procedure for the following:		
	Written Application for Employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Legally-Prohibited Discrimination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Employee Disciplinary Actions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Terminations, Layoffs, Early Retirements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Employee Appraisals / Reviews?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sexual Molestation / Sexual Harassment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Is there any employee training provided regarding the above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Do you have an employee handbook?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, is it distributed to all employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, is employee signature required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Employee Turnover for the Last Three Years:		
	Full-Time Employees Hired:	Part-Time Employees Hired:	
	Full-Time Employees Terminated:	Part-Time Employees Terminated:	
5.	What is the advance review procedure for employee termination? Is legal counsel consulted?		
6.	Are there any facts or circumstances that may result in employment-practice claims being made against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, please provide a listing of each instance:		

Applicant Name:

Sexual Abuse – General Information

A. Nature of Custodial Care Exposure

1. Describe all positions involving adult-minor interaction (outside of the usual teacher/student, coach/athlete, counselor/student, etc.):

Also, describe fully any volunteer activities:

2. Overnight Activities? Yes No

If yes, please describe, including dormitories or sleeping facilities:

3. Have there been incidents of sexual or physical abuse in connection with your operation? Yes No

If yes, please explain:

4. Have there been investigation(s) of your operations by any public authority relating to sexual or physical abuse? Yes No

If yes, please explain:

5. The staff breakdown by age of child is: How Many?

Child(ren) Younger than 2 Years of Age: Staff Member(s):

Child(ren) 2-3 Years of Age: Staff Member(s):

Child(ren) 4-5 Years of Age: Staff Member(s):

Child(ren) 6-7 Years of Age: Staff Member(s):

Child(ren) 8 Years of Age & Above: Staff Member(s):

B. Selection Procedures

6. Do you require a written application for all volunteers and employees? Yes No

7. Is there a pre-employment background check conducted for all employees and volunteers? Yes No

If yes, how:

Does a Background Check Information Include:

A. Personal References? Yes No

B. Police Record Check? Yes No

C. Child Abuse Register? Yes No

Applicant Name:

Sexual Abuse – General Information – Cont.

8. Do you use any form of psychological profiling or abuse screening techniques?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe:		

Sexual Abuse – Controls

A. Documented Policy / Procedure Manual

1. Do you have a written procedural manual that contains:		
A. A commitment to child safety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. A child protection policy with assigned responsibilities and accountabilities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Procedures to be followed in the event of an allegation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Restrictions on one-to-one activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Procedures to be followed in the event of an allegation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F. Are rules concerning sexual and physical abuse in place and communicated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G. Corporal punishment policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

B. Employee and Volunteer Training

2. Do you have an Orientation Program which all staff members and volunteers are required to complete?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Does the Orientation Program include any of the following:		
A. A review of the facilities' policies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Abuse recognition and response?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Rules and procedures for child protection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Handbooks and documentation of training courses completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Informing new employees/volunteers there is zero tolerance for sexual/physical abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F. Probationary/observation period for new employees/volunteers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Do you offer any on-going or repetitive training for existing employees / volunteers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Are the following rules enforced? (All Items must be completed.)		
A. Two Person Rule – No adults are alone with a child.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Transportation is done by two adults, or very strict time and routes which are enforced.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Child custody is pre-established for pickup and visits.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Secret organizations, exclusive clubs, etc. are not tolerated.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Overnight activities are clearly planned and approved by management. Adequate number of pre-approved staff / volunteers, no single adult / child shared sleeping accommodations.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F. Off premises activities are only done with two or more prepared staff / volunteers.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G. All areas are checked on an unannounced basis during each week.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
H. No child(ren) left alone without any adult supervision.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Are unannounced parental visits and program involvement encouraged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Is there a "buddy" system in place for children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Describe your Complaint Handling Procedures: (include investigation, documentation, and action steps)		
Are they displayed prominently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Applicant Name:

Sexual Abuse – Controls – Cont.

B. Employee and Volunteer Training – Cont.

9. What procedures have been instituted to prevent reoccurrence of previous events?

Other Insurance

10. Do you have any other insurance in place (i.e. professional coverage) which would respond to sexual and physical abuse claims? Yes No

If yes, please describe:

Sexual Harassment

Please read end statement carefully.

A. General Information

List the Five Sites with the Greatest Number of Employees:

1.

2.

3.

4.

5.

Are there any foreign operations? Yes No

Coverage Desired (if different from expiring):

Limits of Liability:

Self-Insured Retention:

Has any insurer ever canceled or non-renewed this type of coverage? Yes No

If yes, please explain:

B. Loss History

Please provide a summary of a minimum of five years of ground up losses for all sexual harassment claims, both State and Federal, Civil and Administrative in the space below.

Date of Claim	Claimant Name	Nature of Claim	Defense Amount	Indemnity Amount	Reserve, If Open	Current Status

Applicant Name:

Sexual Harassment – Cont.

B. Loss History – Cont.

Are you aware of any facts/incidents/circumstances which may result in claims being made against you? Yes No

C. Employees

Number of Full-Time Employees:

Number of Part-Time Employees:

D. Claims Handling

With respect to claims incidents, etc. do you have a written procedure for obtaining information? Yes No

If yes, please attach a copy.

E. Risk Management

1. Does the applicant have a Human Resources or Personnel Department? Yes No

If no, please describe handling of this function:

2. Does the applicant have a Sexual Harassment policy? If yes, please attach a copy. Yes No

3. Does the policy include a clear and open reporting procedure? Yes No

4. Is the policy "Zero Tolerance"? Yes No

5. Is the policy understandable – clear and concise? Yes No

6. Is training provided to all supervisory personnel? Yes No

7. Is training documented in their supervisory file? Yes No

8. Does senior management support policy? Yes No

9. Is the policy disseminated to all employees? Yes No

10. Are new employees provided with a copy of the policy at orientation? Yes No

11. Is training on policy offered to all employees? Yes No

12. Is training documented in their personnel files? Yes No

13. Has legal counsel reviewed the policy? Yes No

If no, please describe or provide separately the review process:

Applicant Name:

Schools

1. Description of School:

2. Public Institution Private Institution

3. Average Daily Attendance:

Preschool: _____
 Kindergarten – 8th Grade: _____
 High School: _____
 Vocational: _____
 College Full-Time: _____
 College Part-Time: _____
 Graduate or Professional: _____

4. Number of Faculty or Staff Members:

5. Total Square Footage of Campus Building (College/Universities Only):

Please Provide Total Daily Attendance Count for the Past Five Years:

Term	Average Daily Attendance

6. Separately Rated Classifications:

Classification - Total No. Of	Exposure	Classification - Total No. Of	Exposure
Physicians / Nurses / EMTs		Restaurants / Commissaries	
Physicians:		Food Receipts:	
Nurses:		Liquor Receipts:	
Student Nurses:		Day Care Operations	
EMTs:		Children Supervised:	
Stadium / Bleachers		Locations:	
Facilities:		Supervisors:	
Seating Capacity:		Swimming Pools	
Stadium Receipts:		Number of Pools:	

7. Other Exposures:

Classification	Exposure?	Coverage Desired?	If yes, how many?
Beaches of Lakes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Watercraft	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospitality or Clinics	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Athletic Programs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Radio Stations	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Applicant Name:

Schools – Cont.

7. Other Exposures: - Cont.					
	Publishing Activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Joint Venture Projects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Charter Schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Students in Practicum	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Police / Security Force	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Utilities

A. Gas Utility – Local Distribution	
1. Total Number of Miles of Gas Pipeline:	
2. Are repair / maintenances records maintained?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the insured responsible for the maintenance and repair of these pipelines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is there a comprehensive plan for replacing of aging distribution lines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are the main shut-off valves and regulating controls indicated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the insured obtain additional insured status on the contractor's policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

B. Electric Utility	
1. Totals Values:	
2. Is the utility operated by the insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the utility provide electrical distribution to other communities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:	
4. Does the utility participate in a regional power pool?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are all distribution lines owned by the insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Turbines:	Size: Age: Fuel:
7. Generators:	Size: Age: Fuel:
8. Number of Substations:	
9. Fenced and secured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Equipped with warning signs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do they include dates of major repairs and replacements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are main shut off valves and regulating controls indicated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Is there a plan in place for the replacement of aging facilities and/or distribution lines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Is servicing and maintenance work subcontracted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does the insured obtain additional insured status on the contractors policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have there been any interruptions in service during the past seven years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	

Applicant Name:

Water Utility / Wastewater Treatment

1. Number of Users:																									
Residency:	_____																								
Commercial:	_____																								
Industrial:	_____																								
2. Gallons Per Year:	_____																								
3. Mile of Pipe:	_____																								
4. Type of Pipe Used:	_____																								
5. Annual Payroll (excluding Clerical):	_____																								
6. Percentage of Work, such as Laying of Water Lines, etc., that is:																									
Undertaken directly by Entity:	_____																								
Performed by Independent Contractors:	_____																								
7. Source of Water Supply:	_____																								
8. Age of System:	_____																								
9. Date Upgraded:	_____																								
10. How often is drinking water tested?																									
By Whom:	_____																								
11. Does entity have water supply tanks?	<input type="checkbox"/> Yes <input type="checkbox"/> No																								
<table border="1"><thead><tr><th>Construction</th><th>Type</th><th>Capacity (gal)</th><th>Date Last Inspected</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td></tr></tbody></table>		Construction	Type	Capacity (gal)	Date Last Inspected																				
Construction	Type	Capacity (gal)	Date Last Inspected																						
12. Type of public protection around the tank base(s) (fencing, lighting, aircraft warning lights, run-off channels, etc.):																									
13. Are tanks inspected by qualified engineers?	<input type="checkbox"/> Yes <input type="checkbox"/> No																								
By Whom:	_____																								
14. Does the system comply with current local and federal standards for hygiene and metals?	<input type="checkbox"/> Yes <input type="checkbox"/> No																								
15. Has the system ever been cited or fined for non-compliance with required standards?	<input type="checkbox"/> Yes <input type="checkbox"/> No																								
If yes, please provide details, copy of non-compliance notice(s) and action(s) taken to correct problem(s).																									
16. Is water provided to neighboring entities?	<input type="checkbox"/> Yes <input type="checkbox"/> No																								
If yes, please describe:																									
17. Total Number of Employees:																									

Applicant Name:

Dam / Levee / Dike

1.	Type of Structure (Dam, Levee, or Dike):	
2.	Hazard Code (1-5):	
3.	Who is responsible for inspections?	
	How often are inspections performed?	
	How are inspections documented?	
4.	Name of Structure:	
5.	Construction (Cement, Earthen, etc.):	
6.	Age of Structure:	
7.	What are the structure dimensions?	
	Acres:	
	Acre Feet:	
	Capacity:	
	Height:	
8.	How is the water level controlled?	
9.	Who has ultimate responsibility for maintaining water level?	
	Who has ultimate responsibility for opening gates during flood conditions?	
10.	How are gates operated?	
11.	Was this structure constructed under the direction of your Public Entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If no, please describe:	
12.	Does the entity have an emergency notification plan? If yes, please attached plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Describe downstream exposures in detail (include distance from structure):	
Please attach copies of most current engineering and/or inspection reports.		

Loss History

Please provide up to ten years prior loss history as outlined below. Losses must be shown from first dollar and include open and closed claims.

1.	Does the Insured reserve only to retention level? If yes, excess claims information must be provided.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	If losses are not broken out by General Liability, Law Enforcement Liability and Public Officials Liability, please confirm that these are all included in the information you have provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Attach Company Loss Runs Including:</p> <ul style="list-style-type: none"> - Date of Loss - Description of Claim / Injury - Total Incurred Amounts - Paid and Reserves Amounts - Line of Business (GL, AL, PD, SB, PL) 		

Applicant Name:

Loss History – Cont.

Losses at 50% (or more) of the proposed SIR for at least the past SIX years:

Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Brief Description:						
Brief Description:						
Brief Description:						
Brief Description:						
Brief Description:						
Brief Description:						
Brief Description:						
Brief Description:						
Brief Description:						

If more, please attach separate page.

Applicant Name:

Third Party Administrators Application

1. Please provide name, address, phone number and key contact of the proposed claim handler:

Contact Name:

Company Name:

Address:

Street

City

State

Zip

County

Phone:

2. Please list the names, experience levels and authority levels of the claims handling staff:

Name	Experience	Authority Level

3. Who is responsible for reporting claims to the excess carrier?

4. Are reserves established for each reported claim?

Yes No

If no, please explain:

5. Describe Method Utilized in Setting Reserves:

Case by Case:

Formula:

Please explain:

6. Who establishes the reserves?

7. Are you in compliance with GASB 10?

Yes No

8. Describe Your Claim System:

Manual:

Automated:

If automated, is software internally-programmed?

Yes No

If automated, is software vendor-programmed?

Yes No

9. If vendor-programmed, please provide name of vendor:

10. How often are claim reports generated?

11. Do your claim reports include details on the current status of each claim, as well as the paid amount, incurred amount and description of loss?

Yes No

12. How is litigation handled?

Yes No

Legal Staff?

Yes No

Independent Counsel?

Yes No

Both?

Yes No

13. Are all claim files and reports centralized and coordinated by one individual?

Yes No

Applicant Name:

Checklist

Have you completed all the applicable sections?	
In particular, please ensure that you have supplied the following:	
- General Information	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Loss Control	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Exposure Summary	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Historical Data	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Net Operating Expenditures & Budget	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Police	<input type="checkbox"/> Yes <input type="checkbox"/> No
- E&O	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Sexual Harassment / Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Safety Manual	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Executive Summary	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Competition Details	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is it a Bid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retail Broker working for a Fee or Commission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature

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 the person to criminal and civil penalties.

Completion of this questionnaire creates no obligation upon the applicant to accept insurance or upon Markel to offer insurance. However, in the event that any insurance offering is accepted by the applicant or is issued by Markel, this questionnaire will form the basis for the acceptance and insurance.

Signature

Company

Printed Name

Street Address

Title

City, State, Zip