

**SUPPLEMENT FOR POST MORTEM SERVICES**

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: \_\_\_\_\_

2. (a) Services provided by the Applicant and percentage of gross revenues derived:

			<b>Percentage</b>
(i) Embalming	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____ %
(ii) Cremation	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____ %
(iii) Funeral Director	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____ %
(iv) Funeral Home	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____ %
(v) Cemetery	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____ %
(vi) Pre-Need Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____ %
(vi) Casket and Other Product Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____ %
(vii) Other (specify) _____			_____ %
<b>TOTAL</b>			<b>100%</b>

(b) If only embalming and cremation services are provided answer the following.

(i) Is the Applicant an owner of or an employee of a funeral home? .....  Yes  No  
If Yes, provide the name of the funeral home and advise of the general and professional liability insurance and limits of liability they maintain.

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

(ii) Does the embalmer have a contract with any funeral home?.....  Yes  No  
If Yes, provide the name of the funeral home and advise of the general and professional liability insurance and limits of liability they maintain.

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

(c) If any pre-need sales are provided answer the following:

(i) Are pre-need sales insured? .....  Yes  No

(ii) If No, provide complete details of how such sales are financed. \_\_\_\_\_

(iii) If Yes, provide the names of all insurance companies that insurance is placed with. \_\_\_\_\_

(iv) Attach a copy of the Applicant's insurance license(s).

3. Does the Applicant contract with any out of state funeral homes?.....  Yes  No  
If Yes, list the states. \_\_\_\_\_

4. Is the Applicant responsible for:

(a) picking up remains from hospitals, hospices or nursing homes? .....  Yes  No

(b) shipping remains out of state? .....  Yes  No

(c) picking up remains from any means of transportation? .....  Yes  No

5. Is the Applicant licensed in all states where services are performed?.....  Yes  No

6. Where are embalming services done:

			<b>Percentage</b>
(i) At the embalmer's own facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(ii) At another location? (specify) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %

7. How many bodies are handled per year? \_\_\_\_\_

8. Describe the procedures that are used to ensure that bodies are given the arranged-for post mortem treatment.

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9. Attach a copy of the consent form used by the embalmer to obtain the family's permission to cremate remains (if applicable).

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent within 60 days of the proposed effective date.

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date