



Specialty Non Profit Package

SPECIALTY NON PROFIT PACKAGE APPLICATION

All questions must answered and application must be signed by applicant.

SECTION I. Background Information:

- 1. Name of Organization:
2. Primary Address: Zip Code:
3. Description of Operation:
4. Number of Years in Operation:
5. Does the organization have tax exempt status as defined by the I.R.S.?
6. Website Address: E-mail Address:

SECTION II. Property (Complete this section for each location to be insured):

- 7. Building Address (if different from above): Zip Code:
8. Mortgagee Clause (if applicable):
9. Building Value (at 80% Coinsurance/Replacement Cost):
10. Personal Property Limit (at 80% Coinsurance/Replacement Cost):
11. Square Footage:
12. Building Age: Age of the Roof:
13. If the roof is flat, has it been re-coated in the past 10 years?
14. Building Construction (please check one):
15. Is all electrical wiring on functional and operational circuit breakers:
16. Aluminum Wiring: Burglar Alarms:
Functioning Smoke Detectors: Protection Class (1-10):
17. Property claims Paid, Reserved or Pending during the last 5 years:

* Note: For any additional coverages other than those listed above you will need to attach the appropriate ACORD application page.

SECTION III. General Liability:

- Limit of Coverage Selected:
18. General Liability claims Paid, Reserved or Pending during the last 5 years:
19. Additional Insureds to be included (List name, address and relationship to the applicant):

20. HIRED AND NONOWNED AUTO:

Check if coverage is desired

- a. Does organization have an automobile policy in place?
b. Does organization own any autos or lease any autos on a long term basis?
c. Does organization require its employees or volunteers to use their personal automobile to conduct the applicant's business on a regular basis?
d. Does organization require its employees or volunteers to transport clients?
e. Does organization regularly deliver goods or products?

SECTION IV. Non Profit Directors & Officers and Employment Practices Liability:

21. Is the Organization involved in product research, development, testing and/or certification? Yes No
22. Does the Organization engage in any disciplinary actions as a result of peer review activities? Yes No
23. Does the Organization administer or sponsor any insurance programs? Yes No
24. Is the Organization involved in any accreditation or standard setting activities? Yes No
25. Is the Organization involved in any labor/union negotiations or collective bargaining activities? Yes No

26. Total number of Employees: Full Time _____ Part Time _____ Volunteers _____ Seasonal _____

27. Number of members: _____ Number of chapters: _____
 If there are chapters, is coverage requested for them under this Policy? Yes No

28. Does the Applicant have any Subsidiaries requiring coverage? Yes No
 If yes, please complete the Non Profit Subsidiary Addendum (NPSADD).

29. Name and title of individual designated to receive all notices on behalf of the Insured: _____
 Title _____ Phone Number: _____

Directors and Officers Liability Insurance carried:

Insurer	Limits of Liability	Premium	Retention	Policy Period
_____	_____	_____	_____	_____

30. Does the organization currently carry General Liability Insurance? Yes No

31. Please provide the following financial information for the last three (3) years. (If organization in existence less than 3 years please provide Budgeted Revenue/Expense statement for next 3 years.)

Year	Total Revenues	Net Income (Loss)	Current Fund Balance*
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____

* Fund balance = Total Assets - Total Liabilities

32. Within the last 5 years, has any inquiry, complaint, notice of hearing, claim or suit been made (including, but not limited to, Equal Employment Opportunity Commission, State Human Rights Boards, Municipal, State or Federal Regulatory Authorities), against the Organization, or any person proposed for Insurance in the capacity of Director, Officer, Trustee, Employee or Volunteer of the Organization? Yes No
 (If yes, please forward a completed USLI supplemental claims application.)

33. Is any person proposed for this insurance aware of any fact, circumstance or situation, which may result in a claim against the Organization or any of its Directors, Trustees, Officers, Employees or Volunteers? Yes No
 (If yes, please forward a completed USLI supplemental claims application.)

SECTION V. Fiduciary Liability (Available for 100 employees or less)

34. Does each Pension Plan use an outside Investment Manager? Yes No
 (If No, Fiduciary will not be offered.)

35. Does each Plan subject to ERISA comply with all applicable requirements of ERISA and the Internal Revenue Code of 1982, as amended (the "Code") including eligibility, participation, vesting, fiduciary responsibility and funding standards? Yes No
 If no, please attach details.

36. In the past two (2) years has there been or is there now under consideration any material changes to a Plan or termination / consolidation of a Plan? Yes No
 If yes, please attach details.

37. Has there been or is there now pending any claims(s) against any proposed Insured arising out of any Plan? Yes No
 If yes, please attach details.

38. Does any proposed Insured have knowledge or information of any act, error or omission which might give rise to a claim under the proposed Fiduciary Liability Coverage? Yes No
 If yes, please attach details.

SPECIAL EVENTS/LIQUOR LIABILITY

Do you host any Special Events located off premises involving those other than your employees? Yes No
 If YES, please complete our Non Profit Package Special Events/Liquor Liability Addendum for each event (NPP ADD SPE 10/04).

New York Disclosure Notice: This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged wrongful acts that took place prior to the retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect and all coverage under the policy ceases upon termination of the policy except for the automatic extended reporting period coverage unless the insured purchases additional extend reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

Virginia Notice: You have an option to purchase a separate Limit of Liability for the extension period, policy common conditions I. If you do not elect this option, the Limit of Liability for the extension period shall be part of and not in addition to the limit specified in the declarations. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

Minnesota Notice: The clause "and/or authorization or agreement to bind the insurance." is replaced with "Authorization or agreement to bind the insurance may be withdrawn or modified based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

Colorado Fraud Statement: 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 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.

District of Columbia Fraud Statement: 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.

Florida Fraud Statement: 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.

Kentucky Fraud Statement: 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.

Maine Fraud Statement: 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.

New Jersey Fraud Statement: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Fraud Statement: 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 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.

Ohio Fraud Statement: 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.

Oklahoma Fraud Statement: 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.

Pennsylvania Fraud Statement: 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 such person to criminal and civil penalties.

Tennessee and Virginia Fraud Statement: 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.

Fraud Statement (All Other States): 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.

Applicant's Signature _____ Title _____ Date _____
(President, Chairperson or Executive Director)

If the primary address of the location listed in item #1 is in the state of **New York, Iowa, or Florida**, the states of **New York, Iowa and Florida** require that we have the name and address of your (insured's) authorized Agent or Broker.

Name of authorized Agent or Broker _____

Address: _____

Agent or Broker License number _____

Mail complete application through local Agent or Broker to: _____