



# Non Profit Premises Preferred Product

## NON PROFIT PREMISES PREFERRED PRODUCT SUPPLEMENTAL APPLICATION

All questions must be answered and application must be signed by applicant.  
Please submit with a completed Acord 125 Application.

### SECTION I. General Information:

1. Name of Organization: \_\_\_\_\_
2. Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_
3. Location Address (if different than above): \_\_\_\_\_ Zip Code: \_\_\_\_\_
4. Description of Operation/Services offered: \_\_\_\_\_
5. Website Address: \_\_\_\_\_
6. E-mail Address: \_\_\_\_\_
7. Does the organization have tax exempt status as defined by the I.R.S.?  Yes  No

### SECTION II. Premise Preferred:

8. Are revenues greater than \$10,000,000?  Yes  No
9. Please provide the square footage of the applicant's premises: \_\_\_\_\_
10. Does the applicant have an international exposure?  Yes  No  
If yes, please provide details \_\_\_\_\_
11. Does the applicant have any of the following exposures?  Yes  No
 

<input type="checkbox"/> Gymnasium	<input type="checkbox"/> Swimming Pool	<input type="checkbox"/> Soup Kitchen	<input type="checkbox"/> Adoption	<input type="checkbox"/> Childcare
<input type="checkbox"/> Habitational	<input type="checkbox"/> Play Center	<input type="checkbox"/> Food Bank	<input type="checkbox"/> Abortion Clinic	<input type="checkbox"/> Thrift Store
12. Does the applicant have a stable or farm exposure?  Yes  No
13. Applicant provides Web and/or Software Development or Programming services?  Yes  No
14. Are there functioning smoke detectors on the premises?  Yes  No
15. Does the risk contain aluminum wiring?  Yes  No
16. Does the risk have 100% of the wiring on functioning circuit breakers?  Yes  No

**Important Note: Coverage is limited to premises liability at the location address(es) scheduled in our policy, subject to the terms and conditions of our policy. The products-completed operations hazard is Not insured.**

### SECTION III. NON PROFIT DIRECTORS & OFFICERS AND EMPLOYMENT PRACTICES LIABILITY (if eligible):

17. Is the Organization involved in product research, development, testing and/or certification?  Yes  No
18. Does the Organization engage in any disciplinary actions as a result of peer review activities?  Yes  No
19. Does the Organization administer or sponsor any insurance programs?  Yes  No
20. Is the Organization involved in any accreditation or standard setting activities?  Yes  No
21. Is the Organization involved in any labor/union negotiations or collective bargaining activities?  Yes  No
22. Total number of Employees: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Volunteers \_\_\_\_\_ Seasonal \_\_\_\_\_
23. Number of members: \_\_\_\_\_ Number of chapters: \_\_\_\_\_  
If there are chapters, is coverage requested for them under this Policy?  Yes  No
24. Does the Applicant have any Subsidiaries requiring coverage?  Yes  No  
If yes, please complete the Non Profit Subsidiary Addendum (NPSADD).

25. Name and title of individual designated to receive all notices on behalf of the Insured: \_\_\_\_\_  
 Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

26. Directors and Officers Liability Insurance carried:

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

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

28. 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

29. 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.)

30. 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 IV. Fiduciary Liability (Available for 100 employees or less):**

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

32. 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.

33. 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.

34. 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.

35. 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.

**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)

Broker's Signature \_\_\_\_\_

Some states require that we have the Name and Address of your (Insured's) Authorized Agent or Broker.

Name of Authorized Agent or Broker \_\_\_\_\_

Address: \_\_\_\_\_

Mail complete application through local Agent or Broker to: \_\_\_\_\_

\_\_\_\_\_