NONPROFITS INSURANCE ALLIANCE (NIA)
Alliance of Nonprofits for Insurance, RRG (ANI)
Nonprofits Insurance Alliance of California (NIAC)
National Alliance of Nonprofits for Insurance (NANI)
Alliance Member Services (AMS)

A head for insurance. A heart for nonprofits. insurancefornonprofits.org

Application No.	
Submission Date	
Broker ID	

NIA Social Service Professional (SSP) Liability Supplemental Application

Brokerage Name		Broker ID	
Broker Contact Name		Broker Contact Email	

Applicant Information

Applicant Name

Requested Effective Date | Requested Expiration Date | Quote Need-by Date

Requested Each Occurrence Limit | Requested Aggregate Limit

PLEASE NOTE: This application is for Social Service Professional Liability coverage and can only be bound in conjunction with a Commercial General Liability policy. For complete instructions on our submission requirements, please visit the New Submissions page of the NIA Broker Portal.

1. Has Applicant filed any insurance claims and/or were any suits filed against it in the past five years? ☐ Yes ☐ No

   If yes, please explain:

2. Does the Applicant currently have Professional Liability coverage? ☐ Yes ☐ No

   If yes:

   a. Who is the current insurer?

   b. What is the current effective date?

   c. What is the current expiration date?

   d. What is the current premium?

   e. What is the current occurrence limit?

   f. What is the current aggregate limit?

   g. Is current coverage written on a claims-made basis? ☐ Yes ☐ No

   If yes:

   Enter the applicable coverage retroactive date

3. Please include the following with the submission (both are required to offer Prior Wrongful Acts coverage):

   a. Your current claims-made policy declarations page with retroactive date.

   b. Signed No-Known Loss Letter on the Applicant's letterhead (No Known Loss Letter Template)

4. Attach currently valued loss runs for the past five years (four years plus current year) as well as a completed NIA Claims Supplemental Application for each claim that has been reported under any Social Service Professional policy. If no coverage was in force, but an incident did occur, please complete the NIA Claims Supplemental Application to describe each incident.

   If none, please check here: ☐

5. Does the Applicant have knowledge, information, or access to information of any act, error, omission, or incident performed in the course of delivering services that might give rise to a claim or suit? ☐ Yes ☐ No

   If yes, a completed NIA Claims Supplemental Application is required for each incident.

6. Indicate the number of professionals that currently work for you as employees, volunteers, and independent contractors in the following professional capacities:

   If none, please check here: ☐

Provider	Employees		Volunteers		Independent Contractors	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Acupuncturist						
Adoption Service Employee						
Aide						
Assisted Living Provider						
Certified Enrollment Counselor						
Childcare Worker						
Chiropractor						
CNA/LPN/Nurse Assistant						
Coach/Assistant Coach						
Companion Care/Home Aide						
Daycare Provider						
Dental Hygienist/Assistant						
Educator/Instructor/Teacher						
Group Home/Supported Living						
Home Health Aide (greater skill)						
Intake Coordinator/Specialist						
Mentor/Tutor						
Nutritionist/Dietician						
Optician						
Personal Care Attendant						
Phlebotomist						
Psychologist/Psychotherapist						
Recreational Instructor						
RN						
Social Worker/Case Worker						
Therapist/Counselor (all)						
Veterinarian						
Other Professionals (describe):						

7. Indicate the number of medical professionals who currently work for the Applicant as employees, volunteers, and independent contractors in the following medical professional capacities:

If none, please check here: ☐

Medical Services Provider	Employees		Volunteers		Independent Contractors	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Dentist						
Nurse Anesthetist, Midwife, and/or Nurse Practitioner						
Optometrist						
Paramedic/EMT						
Pharmacist						
Physician Assistant						
Physician/Surgeon/Psychiatrist						

PLEASE NOTE: NIA's policy may extend vicarious professional coverage to the nonprofit entity as respects professional services rendered on the insured's behalf only if the above employed or volunteer professionals carry their own medical malpractice insurance with a minimum limit of liability of $1 million.

8. If you did not enter any employees for questions 3 or 4, what employees and/or related services are you seeking Social Service Professional coverage for?

Please describe:

9. Is a complete criminal background check required for all contracted and employed staff members and volunteers? ☐ Yes ☐ No

If yes:

a. Are formal written procedures in place for staff hiring? ☐ Yes ☐ No

b. Are prior employment and personal references verified prior to hiring? ☐ Yes ☐ No

10. How many hours per week constitute "part-time" for professionals who volunteer for your organization?

11. Does the Applicant use any independent contractors to perform professional services on behalf of the nonprofit? ☐ Yes ☐ No

If yes:

a. Are contractors required to sign a hold harmless or indemnification agreement? ☐ Yes ☐ No

b. Are certificates of insurance for each independent contractor reflecting minimum limits of liability of $1 million required and maintained on file? ☐ Yes ☐ No

c. Does the Applicant require that all independent contractors name the organization as an Additional Insured? ☐ Yes ☐ No

PLEASE NOTE: Typically, independent contractors/1099 workers are expected to procure their own insurance. See NIA Social Service Professional Liability form for details on specifically excluded occupations.

12. Has the Applicant's management or staff ever:
    a. Been reprimanded, refused admission to, or suspended by any association or administrative agency? ☐ Yes ☐ No
    b. Had their license under investigation, suspended, revoked, voluntarily surrendered, or placed under conditional status? ☐ Yes ☐ No

    If yes to either question above, please provide details:

13. Does the Applicant verify licenses and other credentials of employees, volunteers, and independent contractors, before they begin work? ☐ Yes ☐ No
    a. **If no**, please explain:

    b. Are procedures in place to verify current licenses are maintained and in good standing? ☐ Yes ☐ No

14. Does the Applicant have a formal incident procedure in place that requires employees, volunteers, and independent contractors to report to an administrator? ☐ Yes ☐ No
    a. **If yes**, is a written record kept and reviewed regularly? ☐ Yes ☐ No

15. What security is provided for protection and/or monitoring of the Applicant's clients/residents?
    ☐ None ☐ Guards ☐ Video Cameras ☐ Other (describe):

16. Does the Applicant prescribe or provide medication to clients/residents? ☐ Yes ☐ No
    If yes, please confirm which procedures are in place when dispensing medications to clients:
    a. Written guardian permission is required. ☐ Yes ☐ No
    b. Medication is kept in its original container/package. ☐ Yes ☐ No
    c. Written instructions for use are provided by the guardian. ☐ Yes ☐ No
    d. Written records are kept of all medications dispensed. ☐ Yes ☐ No

17. Does the facility require that incoming clients stop taking all prescription medications the client is taking? ☐ Yes ☐ No

18. Does the facility use alternative methods of treatment such as the holistic method or otherwise? ☐ Yes ☐ No

19. Does the facility utilize massage therapy as part of their services or treatment process? ☐ Yes ☐ No

20. Does the facility utilize a sauna or steam treatments as part of their detoxification process? ☐ Yes ☐ No

21. Are clients required to sign a Statement of Faith in order to receive services? ☐ Yes ☐ No

22. Does the Applicant provide any sort of drug detoxification/medication-assisted treatment (i.e., methadone, suboxone, etc.)? ☐ Yes ☐ No

23. Does the Applicant operate a crisis hotline? ☐ Yes ☐ No
    a. **If yes**, is training provided to all employees/volunteers answering calls? ☐ Yes ☐ No

24. Does the Applicant provide direct services to registered sex offenders? ☐ Yes ☐ No
    If yes, please explain:

Home Health Services

25. Does the Applicant provide home health services? ☐ Yes ☐ No

If yes, does the Applicant:

a. Provide catheterization, feeding tube maintenance, or injection of prescribed medications? ☐ Yes ☐ No

If yes, please explain:

b. Require a written plan by clients' attending physician prior to being accepted for home health services? ☐ Yes ☐ No

c. Require all clients receiving any level of skilled care to have a current and regularly updated physician treatment plan on file? ☐ Yes ☐ No

d. Have written, enforced, and monitored policies and procedures in place regarding the following?

1. Medical record documentation ☐ Yes ☐ No
2. Incident reporting ☐ Yes ☐ No
3. Employee training ☐ Yes ☐ No
4. Handling of complaints ☐ Yes ☐ No
5. When providers should contact a physician ☐ Yes ☐ No
6. Client care home visits documentation ☐ Yes ☐ No
7. Clients no longer meet the criteria for home care ☐ Yes ☐ No
8. Clients should be transferred to a hospital ☐ Yes ☐ No

e. If you answered "**no**" to any of the questions above, please explain:

Additional Remarks

The following language applies to ANI applicants for Liability coverages only:

Notice:

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

The following language applies to NIAC applicants for Liability coverages only:

Notice: This risk pooling contract is issued by a pooling arrangement authorized by California Corporations Code Section 5005.1. The pooling arrangement is not subject to all of the insurance laws of the State of California and is not subject to regulation by the Insurance Commissioner. Insurance guaranty funds are not available to pay claims in the event the risk pool becomes insolvent.

Important Notice: NIA's policy may not afford coverage to any claim, incident, suit, complaint, or situation the Applicant knew of prior to the effective date of the proposed policy. It is important that all such incidents that may give rise to a claim be reported to the current insurer.

NONPROFIT APPLICANT APPROVAL

Please read this carefully.

By entering my name and job title, I confirm that this signature will be the electronic representation of my signature for all purposes, just the same as a manual signature when I or my agent use them on documents including **legally binding** contracts.

I certify that the broker listed on page 8 has binding authority to fill out and submit this application on behalf of the Applicant, that all information supplied by the Applicant and provided in this application is truthful, and that NIA will rely on the information provided and referenced in this application to make all decisions related to the application and any associated underwriting decisions.

_____

Nonprofit Applicant's Organization Name

_____

Nonprofit Applicant Representative's Name - Electronic Signature (Type Your Name Here)

_____ _____

Nonprofit Applicant Representative's Title **Date**

BROKER SIGNATURE

Please read the following and confirm agreement below:

Information submitted in this application will be reviewed by an underwriter to determine coverage that can be offered. Failure to provide a quotation with coverages different from those requested shall impose no liability on any of the companies of Nonprofits Insurance Alliance (AMS, NIAC, ANI, AMSIS) or SRCS Elite or QBE Insurance Corporation (QBE).

I acknowledge that I have the authority to bind the Applicant, that all information provided in this application is truthful, and that NIA will rely on the information provided and referenced in this application to make all decisions related to the application and any associated underwriting decisions.

I further certify that I am electronically signing the application as if I were physically signing it. The insurer may rely upon my electronic signature as if the application were physically executed and, if requested, I will supply a physical signature.

Broker's Signature | **Broker Agency Name**

Print or Type Broker's Name | **Broker's Title** | **Date**