



# Comprehensive Social Service application

P.O. Box 2009 • Glen Allen, VA 23058-2009  
Phone: (800) 431-1270 • Fax: (804) 527-7966  
Email applications to: [msscsubmissions@markelcorp.com](mailto:msscsubmissions@markelcorp.com)

## Not to be used with child welfare application (Attach ACORD Applications)

Markel agent number: \_\_\_\_\_  
Named insured: \_\_\_\_\_ DBA name: \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Website: \_\_\_\_\_  
Contact person and phone number: \_\_\_\_\_ FEIN: \_\_\_\_\_

### Section 1 – GENERAL INFORMATION

1. Full description of all operation(s) and types of clients served: \_\_\_\_\_  
\_\_\_\_\_
2. Type of entity:  For profit  Non-profit  Governmental/public  Other: \_\_\_\_\_
3. a. Number of years in operation: \_\_\_\_\_ Years under present management: \_\_\_\_\_  
*If a new operation, or new leadership, send a copy of the CEO or director's resume.*
4. a. Licensed by: \_\_\_\_\_  
b. Has license ever been suspended or revoked?  Yes  No If yes, provide details and explanation: \_\_\_\_\_  
\_\_\_\_\_
- c. Has the organization received any citations from a licensing agency in the past 5 years?  Yes  No  
d. If yes, provide details and explanation: \_\_\_\_\_
5. Are you accredited?  Yes  No If so, by which accreditation organization? \_\_\_\_\_
6. List professional organization memberships: \_\_\_\_\_
7. a. What is your annual operating budget? \_\_\_\_\_  
b. Breakdown of all funding sources by program: \_\_\_\_\_  
\_\_\_\_\_
8. Have you discontinued any programs in the past 5 years?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
9. a. Have you been involved in any mergers or acquisitions in the past 3 years?  Yes  No  
b. If yes, please provide full details: \_\_\_\_\_

### Section 2 - FACILITIES/OPERATIONS

1. Do you operate a camp?  Yes  No (if yes, complete the Camp application)
2. Do you operate a foster care/adoption agency?  Yes  No ( If yes, complete the Child Welfare application **instead**)
3. Do you operate a private school or child care?  Yes  No ( If yes, complete the Child Care Complete, Independent School Programs application)
4. a. Do you operate a crisis hotline?  Yes  No  
b. If yes, describe types of calls, staff qualifications: \_\_\_\_\_  
\_\_\_\_\_

5. Do your facilities have the following life safety features? (check all that apply):
- Smoke detectors  Fire alarms  Manual pull alarms  Illuminated exit signs  Emergency lighting
- Fire extinguishers with current inspection tags  Evacuation routes posted throughout the building
- At least two unobstructed means of egress on each floor  Carbon monoxide detectors
6. Do you have a formal written safety and evacuation program in place?  Yes  No
7. a. Is the staff required to report all incidences that may result in a claim?  Yes  No
- b. Are all incidents reviewed by the organization?  Yes  No
- c. If yes, is the data used to implement improved safety programs?  Yes  No
- d. By whom? \_\_\_\_\_
8. a. Are medications dispensed?  Yes  No
- b. If yes, where are they stored? \_\_\_\_\_
- c. Are medications locked up whenever they are not being dispensed?  Yes  No
- d. Who has the authority to dispense medications? \_\_\_\_\_
- e. Can over-the-counter medicines be dispensed without written permission from a doctor?  Yes  No
- f. Are written records kept as to time, type of medication, amount of dosage and who dispensed the medications?  Yes  No
9. Is there always someone trained in CPR and First aid on the premises?  Yes  No
10. a. Do you rent your facility to outside groups?  Yes  No What are your gross receipts from all rental operations? \_\_\_\_\_
- b. Is a written lease spelling out safety requirements required for every rental?  Yes  No
- c. Do you obtain certificates of insurance with liability limits of at least \$1,000,000?  Yes  No
- d. Are you named as an additional insured on their insurance?  Yes  No
11. a. Do you provide any mentoring or coaching?  Yes  No
- b. If yes, is mentoring one on one?  Yes  No Is mentoring done in a group setting?  Yes  No
- c. How are activities conducted and supervised? \_\_\_\_\_

**Section 3 – PROFESSIONAL**

1. Do you currently carry professional liability insurance?  Yes  No Indicate:  Occurrence  Claims made
- b. If yes, indicate limits, carrier, and retro date (if any). \_\_\_\_\_
- 
2. Total number of staff: \_\_\_\_\_ Annual staff turnover rate: \_\_\_\_\_%

**Staff list**

Positions	# full time employees	#part time employees	# licensed employees	# contracted employees
Administrators				
Certified nurse assistants				
Child care workers				
Counselors				
Maintenance/janitorial				
Nurses, L.P.N.				
Nurses, R.N.				
Nurse practitioners				
Occupational therapists				
Physical therapists				
Physicians				
Psychiatrists				
Psychologists				
Residential staff				
Social workers				
State licensed clinicians				
Teachers				
Others: (List)				

3. Do you require continuing education for all your staff?  Yes  No
4. a. Does the organization provide coverage for all licensed staff?  Yes  No  
 b. Are licensed staff required to carry their own malpractice insurance?  Yes  No  
 c. What are the minimum limits required: \_\_\_\_\_
5. Do any contracted employees need to be covered under this policy?  Yes  No
6. If contracted professionals are used, does the insured require them to sign a hold harmless or indemnification agreement?  
 Yes  No
7. Are certificates of insurance required and kept in file for those contracted professionals?  Yes  No
8. a. Is a complete criminal background check required for all contract and employed staff members and volunteers?  Yes  No  
 b. If yes, check all you use:  County criminal record search  State criminal record search  
 National criminal index search  State prison search  Federal prison search  Sex offender search  
 Criminal index search  Nationwide U.S. Wants & Warrants search  Teacher license  FBI  Education verification?
9. Are formal written procedures in place for staff hiring?  Yes  No
10. Are prior employment and personal references verified prior to hiring?  Yes  No
11. Are licenses and other credentials verified prior to hiring?  Yes  No
12. a. Do you have volunteers?  Yes  No Total number of volunteers: \_\_\_\_\_  
 b. Describe the volunteers' duties. \_\_\_\_\_  
 \_\_\_\_\_  
 c. Are any volunteers working off court-mandated community service?  Yes  No  
 d. If yes, explain: \_\_\_\_\_
13. a. Do you handle clients' money, bills or finances of any type?  Yes  No  
 b. If yes, explain what is handled and what controls are in place. \_\_\_\_\_  
 \_\_\_\_\_  
 c. Have there been any claims or suits, or do you know of any incidents that could result in a claim or suit of any type relating to handling of finances?  Yes  No  
 d. If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_
14. Are all staff members and volunteers formally trained and certified in the type of counseling they're doing?  Yes  No
15. Are clients referred to specialists when appropriate?  Yes  No
16. Are files maintained to protect confidentiality of clients?  Yes  No
17. Do you provide any in home services?  Yes  No If yes, describe: \_\_\_\_\_

**Section 4 – ABUSE AND MOLESTATION**

1. Do you have a formal, documented abuse policy?  Yes  No  
*Does it include:*
- a. A screening process that includes background checks, reference checks, personal interviews prior to hiring and an employment application that asks questions about whether or not an applicant has been convicted of any crime?  Yes  No
- b. Documented, annual training with staff/ volunteers including how to identify symptoms or signs of abuse with a recommended course of action?  Yes  No
- c. A plan of supervision that monitors staff in day-to-day relationships with clients/children, both on and off insured premises?  Yes  No
- d. A plan of direct supervision that monitors clients/children by sight and hearing with maximum visibility maintained throughout the facility?  Yes  No
- e. A clear policy regarding isolated or one-on-one situations?  Yes  No

- f. A policy with restrictions on use of electronic devices and social media, including interaction with clients/youth outside of normal work hours?  Yes  No
- g. Protocols on reporting incidences and suspicious or inappropriate behavior?  Yes  No
- h. Review of any incident to determine if actions need to be taken to prevent any similar future incident?  Yes  No
2. Are criminal investigations/background checks allowed in your state/states?  Yes  No
3. Are criminal investigations/background checks conducted on all employees and volunteers before hiring and with recurring checks at least every 3 years?  Yes  No
- Do you include:*
- a. A multi-state criminal search compiled for at least a 5 year history?  Yes  No
- b. Check of the sex offender registry?  Yes  No
- c. A social security identification and alias trace?  Yes  No
4. Have you had any abuse incidents, claims or suits, or do you have any knowledge or information which might reasonably be expected to give rise to a claim of sexual or physical abuse or molestation?  Yes  No
- If yes, provide details: \_\_\_\_\_

**Section 5 – RESIDENTIAL** .....N/A

Type of Facility	# of residents	Staff to client ratio		# of non-ambulatory clients	Average length of stay
		Day	Night		
Domestic Abuse					
Emergency Shelter					
Group Homes					
Homeless					
Independent Living Skills					
Lockdown / detention					
Psychiatric Facility					
Substance Abuse					
Runaway Youth					
N/A					

1. Do you have any live-in staff members?  Yes  No If so, how many? \_\_\_\_\_
2. Was the building originally designed and built for the insured occupancy?  Yes  No
3. a. Are patients/clients primarily responsible for their own basic needs  Yes  No  
 b. Does this include:  bathing  eating  dressing  restroom aid
4. Is staff trained in non-violent crisis intervention?  Yes  No
5. a. Is physical restraint allowed in your state?  Yes  No  
 b. Does your agency utilize restraint?  Yes  No  
 c. If yes, what method of restraint is utilized? \_\_\_\_\_  
 d. Are Staff trained/certified in this method?  Yes  No
6. Do any residents have prior involvement with acts of property damage, e.g. arson or vandalism?  Yes  No  
 If yes, explain: \_\_\_\_\_
7. Are you the appointed legal guardian for any of the residents?  Yes  No

8. Is the insured responsible for obtaining medical treatment for residents?  Yes  No
9. Is the insured responsible for maintaining medical records for the residents?  Yes  No
10. Describe recreational activities on and off premises: \_\_\_\_\_
- 
11. Explain management controls for visitors on premises: \_\_\_\_\_
- 
12. If clients are confidentially placed, describe controls to maintain secrecy of the location: \_\_\_\_\_
- 
13. Are fire drills conducted?  Yes  No If yes, how often? \_\_\_\_\_
14. Are evacuation procedures & floor plans posted?  Yes  No
15. How often are rooms inspected? \_\_\_\_\_ Who performs the inspection? \_\_\_\_\_
16. a. Are bathing facilities equipped with grab bars, non-slip surfaces & water temperature control devices?  Yes  No  
 b. Is the water temperature set at 100 degrees maximum?  Yes  No
17. If residents cook, is the cooking supervised?  Yes  No
18. Are residents required to notify the facility when leaving or returning?  Yes  No
19. Are complete records kept on all residents?  Yes  No
20. Does the facility have a written emergency evacuation plan?  Yes  No

**Section 6 – SUBSTANCE ABUSE N/A**

1. Is treatment:  Individual - number of annual sessions \_\_\_\_\_ or  Group – number of annual sessions \_\_\_\_\_
2. a. Do you have a methadone maintenance program?  Yes  No  
 b. Number of methadone-only clients: \_\_\_\_\_  
 c. Number of clients with take home privileges: \_\_\_\_\_  
 d. Where is the methadone stored? \_\_\_\_\_  
 e. Describe measures to guard against the diversion of methadone by employees and/or clients: \_\_\_\_\_
- 
3. Do you use aversion therapy for alcohol addiction?  Yes  No
4. a. Do you operate a detoxification unit?  Yes  No How many people annually: \_\_\_\_\_  
 b. If yes,  Medical  Other \_\_\_\_\_  
 c. If medical, do you accept clients with a history of delirium tremens (DT's) or seizures?  Yes  No  
 d. If clients are experiencing DTs or seizures do you:  Treat them  Refer them to a hospital
5. a. Do you operate drug/alcohol rehabilitation?  Yes  No  
 b. If yes, for adults only?  Yes  No

**Section 7 –SERVICES FOR SPECIAL NEEDS INCLUDING OUTPATIENT CLINICS AND MENTAL HEALTH N/A**

1. Annual number of clients by age group: \_\_\_\_\_ less than 18 \_\_\_\_\_18-35 \_\_\_\_\_35-65 \_\_\_\_\_over 65
2. What type of services are offered? \_\_\_\_\_
3. Do you operate a clinic?  Yes  No If yes, is it open to the public?  Yes  No
4. a. Do you offer group therapy?  Yes  No  
 b. If yes, what is the average size? \_\_\_\_\_ How often do they meet? \_\_\_\_\_
5. Do you provide off-site counseling?  Yes  No Location: \_\_\_\_\_
6. What is the level of support given to clients?  Intermittent (episodic)  Limited (for specified periods of time)  
 Extensive (regular for extended periods of time)  Pervasive (life-long, intense)

7. a. What percentage of clients are mentally challenged? \_\_\_\_\_ %  
 b. Is the mental retardation:  Mild (IQ 70 to 55/50)  Moderate (IQ 55/50 to 40/35)  Severe (40/35 to 25/20)  
 Profound (IQ below 25/20)
8. What percentage of clients are physically challenged? \_\_\_\_\_ %
9. a. Any residents with serious psychotic, disorders, such as schizophrenia, bi-polar disorder, etc.?  Yes  No  
 b. If yes, describe: \_\_\_\_\_
10. Does the insured offer any of the following?  Hands-on assistance with activities of daily living  Physical rehabilitation  
 Skilled nursing care  Other medical care (describe): \_\_\_\_\_
11. a. Is physical restraint allowed in your state?  Yes  No b. Does your agency utilize restraint?  Yes  No  
 c. If yes, what method of restraint is utilized? \_\_\_\_\_  
 d. How are staff trained in appropriate use of restraint? \_\_\_\_\_
12. a. Do you provide any medical services?  Yes  No  
 b. If yes, do you provide anything other than immediate care/first aid?  Yes  No  
 c. If yes, describe \_\_\_\_\_  
 d. Do you maintain medical history and care records for each individual?  Yes  No For how long? \_\_\_\_\_

**Section 8 – VOCATIONAL/SHELTERED WORKSHOPS N/A**

1. Number of clients daily: \_\_\_\_\_ Age range of clients: \_\_\_\_\_
2. Describe type of work performed: \_\_\_\_\_
3. a. Does the applicant perform industrial sub-contracted work (e.g. packaging, assembling, and actual manufacturing of a finished product)?  Yes  No  
 b. If yes, what company label goes on the product: \_\_\_\_\_
4. a. Do clients work with power equipment?  Yes  No  
 b. If yes, describe safety measures and supervision: \_\_\_\_\_
5. a. Are janitorial services performed for others?  Yes  No  
 b. If yes, describe safety measures and supervision: \_\_\_\_\_
6. a. Any woodworking of any type?  Yes  No  
 b. If yes, describe dust control systems, spraying safeguards & ventilation: \_\_\_\_\_
7. a. Any plastics manufacturing of any type?  Yes  No  
 b. If yes, describe dust control, heat safeguards & ventilation: \_\_\_\_\_
8. a. Any use of chemicals?  Yes  No  
 b. If yes, describe types, quantities and how stored: \_\_\_\_\_
9. a. Do your products produce any fumes, acids or waste?  Yes  No  
 b. If yes, describe how these exposures are controlled: \_\_\_\_\_
10. a. Does your facility have a formal training program for staff?  Yes  No  
 b. Does it include the following:  Emergency procedures including first aid  Review of labor laws  
 Training in recognition of problems with clients  Formal quality control procedure for manufactured items
11. Are hold harmless/contractual agreements signed with customers?  Yes  No

**Section 9 – FOOD BANK/THRIFT STORE N/A**

1. Indicate layout of facility:  Grocery store  Self-service warehouse  Full service  Department store
2. Is all equipment (lifting jacks, ladders, rolling pallets, carts, etc.) inspected and maintained regularly?  Yes  No
3. Are aisles kept clear and unobstructed?  Yes  No
4. Is there a schedule for sweeping/monitoring walk areas?  Yes  No If yes, what is the frequency? \_\_\_\_\_

5. a. Are any of the following allowed in the warehouse/store?  Eating  Drinking  Running  Smoking  None  
 b. Are signs posted forbidding these actions?  Yes  No
6. Is there an inventory policy in place to adequately document all goods?  Yes  No
7. Are expiration dates checked on all items?  Yes  No
8. Check all of the following signage posted in the facility:  Rules outlining standards of operation  Off-limit areas  Request for customers to seek assistance with reaching high shelves, operating equipment and loading or lifting heavy items
9. Are fork lift operators properly trained and supervised?  Yes  No
10. Do you have a loading dock or appropriate place to unload goods?  Yes  No

**Section 10 – WEATHERIZATION N/A**

1. Is weatherization performed by: Your employees?  Yes  No By subcontractors?  Yes  No
2. Describe all services performed: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Do any of your employees do insulation?  Yes  No If yes, what is the payroll? \_\_\_\_\_
4. Do any of your employees do carpentry?  Yes  No If yes, what is the payroll? \_\_\_\_\_
5. What operations are subcontracted? \_\_\_\_\_
6. What is the payroll of the subcontracted work? \_\_\_\_\_
7. a. Are all contractors providing you with a certificate of insurance with at least \$1m in limits ?  Yes  No  
 b. Does the certificate name you as Additional Insured?  Yes  No

**Section 11 – FUNDRAISING N/A**

	Event 1		Event 2		Event 3	
Description of event						
Location						
Participants/attendance						
Number of staff/workers						
Security provided? Will they be armed?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
Who will provide the security?						
Will alcohol be present?	Yes	for a charge?	Yes	for a charge?	Yes	for a charge?
Will it be served by you or by a third party vendor?	Self	3rd party vendor	Self	3rd party vendor	Self	3rd party vendor
Is a drink maximum imposed on attendees? (List drink max.)						
Do servers have TIPS training?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are certificates of insurance obtained from all vendors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are waivers signed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Section 12 – AQUATIC N/A**

1. Is swimming facility (check all that apply):  Private  Public  River/Lake/Ocean  On premises  Off premises  
 Indoor  Outdoor  Below ground  Other \_\_\_\_\_
2. If on premises, is pool used exclusively for center’s clients?  Yes  No
3. Are all pools used (including those not belonging to you) compliant with the Virginia Graeme Baker Pool & Spa Act?  Yes  No
4. a. Is there a lifeguard on duty?  Yes  No If yes, how many? \_\_\_\_\_  
 b. Lifeguard to swimmer ratio: \_\_\_\_\_ Total staff to swimmer ratio: \_\_\_\_\_

5. Is pool completely fenced with a self-locking gate?  Yes  No  N/A
6. Is all staff watching the pool placed in positions where they can see all areas of the pool including the bottom?  Yes  No
7. Are there any of the following (check all that apply)?  None  Diving board  Pool trampoline  Water blobs  
 Racing blocks  Starting blocks  Water slides
8. Are all pool depths marked?  Yes  No What is the max depth? \_\_\_\_\_ What is the min. depth? \_\_\_\_\_
9. Are warning signs and facility rules posted?  Yes  No
10. a. Do you test each swimmer's swimming ability prior to allowing them to use the facility?  Yes  No  
b. If so, are non-swimmers identified?  Yes  No
11. Are all chemicals kept in a dry ventilated, locked storage area?  Yes  No
12. Do you have any of the following safety equipment? (check all that apply)  
 Backboard  Portable oxygen  AED  First aid kit  Ring buoy  Reaching pole

**Section 13 – AUTOMOBILE (including hired and non-owned) N/A**

1. Are driver motor vehicle reports checked prior to hiring?  Yes  No
2. Do drivers have the appropriate types of licenses for vehicles driven (i.e., buses, heavy trucks, etc.)?  Yes  No
3. Do you have a written rules and regulations/Standard Operating Procedures (SOP) that describes the requirements for drivers and for vehicle use? Check all that apply:
  - A final check is performed after unloading to be sure nobody is left inside when vacating the vehicle?
  - Driving the speed limit (no speeding)?
  - Keys being locked and secured away from clients when not in use?
  - Limitations on distracted driving (cell phone use) and prohibiting reading or sending texts?
  - Mandatory seat belt use by all in vehicle?
  - Mandatory use of wheelchair (and passenger) tie-downs?
  - Pre-trip vehicle inspections?
  - Vehicle incident reporting procedures?
  - Vehicle maintenance and inspections?
4. Have drivers attended a driver training program and is all training documented? Check all that apply:
  - Defensive driving
  - Driver rules and regulations/SOPs
  - DUI / DWI awareness
  - Proper use of child restraint systems
  - Training specific any other type of vehicles you may use (i.e. 15-passenger vans)
  - Wheelchair tie-down training
5. Is personal use of agency's automobiles permitted?  Yes  No
6. Are family members permitted to drive the agency's automobiles?  Yes  No
7. a. Do your employees or volunteers use their own vehicles on agency business?  Yes  No  
b. If yes, what percentage of employees regularly uses their own vehicles for business? \_\_\_\_\_ %  
c. If yes, do they use their own vehicles to transport clients?  Yes  No
8. a. Do you require your employees or volunteers to carry and provide evidence of personal auto insurance?  Yes  No  
b. If yes, what minimum liability limits do you require they have? \_\_\_\_\_
9. a. Are all vehicles insured on the schedule titled to the named insured?  Yes  No  
b. If no, explain: \_\_\_\_\_
10. Do all large capacity vehicles (> 8 passengers) have an audible backup warning device?  Yes  No
11. Are any drivers under 21?  Yes  No
12. a. Are any vehicles leased or hired?  Yes  No  
b. If yes, describe what types, what uses and how often: \_\_\_\_\_
13. a. Are clients permitted to drive insured vehicles?  Yes  No  
b. If yes, explain in detail: \_\_\_\_\_



**Section 14 – DONATED VEHICLES**

**N/A**

1. Approximately how many vehicles a year are donated? \_\_\_\_\_
2. What are your requirements for donation? (age, condition, etc.)? \_\_\_\_\_
3. When and how does the title transfer to you? \_\_\_\_\_
4. Where are the vehicles stored? \_\_\_\_\_
5. a. Do you do any repair/alterations on any vehicles?  Yes  No  
b. If yes, describe the repairs/alterations: \_\_\_\_\_  
c. Who is doing the repairs/alterations? \_\_\_\_\_  
d. Do you sell the vehicles "as is" with no guarantees?  Yes  No

Additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SUBMISSION ATTACHMENTS**

- Fully completed and signed ACORD applications
- Three-year currently valued company loss runs including details of losses over \$5000
- Driver list
- MVR's if available
- Photographs of each location if available
- Brochure, website, or information describing your operation
- Sample contracts and/or hold harmless agreements used for contracted staff
- Financial statement
- Supplemental questionnaires as required

**Please read and sign next page to complete this application.**

**Notice of Insurance Information Practices:** Personal information about you may be collected from persons other than you in connection with this application for insurance. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. You have the right to review your personal information in our files and can request correction of any inaccuracies. A more detailed description of your rights and our practices regarding such information is available upon request. Contact your agent or broker for instructions on how to submit a request to us.

**Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or another 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 [NY: substantial] civil penalties. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied).

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**STATE FRAUD STATEMENTS**

**APPLICABLE IN COLORADO**

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**APPLICABLE IN THE DISTRICT OF COLUMBIA**

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.

**APPLICABLE IN FLORIDA**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**APPLICABLE IN HAWAII**

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim or payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**APPLICABLE IN KANSAS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN MARYLAND**

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT**

Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the personal to criminal and civil penalties.

**APPLICABLE IN MINNESOTA**

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**APPLICABLE IN OHIO**

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deception statement is guilty of insurance fraud.

**APPLICABLE IN OKLAHOMA**

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.

**APPLICABLE IN WASHINGTON**

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.

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**Authorization** - I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

**NOTE:** Coverage cannot be bound until the Company approves your completed application. The Company's receipt of premium does not bind coverage until a written quote has been issued.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

How did you hear about Markel:  Magazine ad  Referral  Convention/Conference  Website  Other

Describe: \_\_\_\_\_