Public Entity Application

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Applicant Name:

General Information

Applicant Name, as to be shown on policy:

Risk Manager Contact/Title:				
Address:				
Street	*City*	*State*	*Zip*	*County*
Phone:	Website URL:			

Broker Name:				
Contact/Title:				
Address:				
Street	*City*	*State*	*Zip*	*County*
Phone:	Website URL:			
Surplus Lines Details / FEIN No.:				
Retail Broker Commission Fee:				

Proposed Effective Date:	**Quote Need By Date:**

1.	Is a full-time risk manager employed?	☐ Yes	☐ No
2.	What is the Bond Rating of The Entity?	Moody's:	
		Standard & Poor's:	
3.	Has any insurance for The Entity been canceled or non-renewed in the last five (5) years?	☐ Yes	☐ No
	If yes, please explain:		
4.	How will claims be handled? ☐ In-House ☐ Independent Administrator/Adjuster ☐ Insurance Company		

If you selected In-House of Independent Administrator/Adjuster, the TPA Section must be completed.

Loss Control Information

Please describe or attach information regarding risk management programs, training programs, and/or safety programs.

1.	Is a full-time safety/loss control person employed?	☐ Yes	☐ No
	If yes, please describe duties:		

2. Do you have any formal written loss control programs in place regarding the third party exposures listed below?

A.	School Board Liability	☐ Yes	☐ No	E.	Vehicles / Fleet	☐ Yes	☐ No
B.	Contractual Liability	☐ Yes	☐ No	F.	Campus Housing	☐ Yes	☐ No
C.	Peer Harassment	☐ Yes	☐ No	G.	Athletic Programs	☐ Yes	☐ No
D.	Employment Related Practices	☐ Yes	☐ No				

3. Please describe or attach the procedures utilized to administer all loss control efforts for item 2, A-G.

Applicant Name:

Loss Control Information – Cont.

4.	Are independent contractors utilized?	☐ Yes	☐ No
	If yes, please describe when & for what purposes:		
5.	Are Certificates of Insurance required?	☐ Yes	☐ No
	If yes, state minimum limits required:		
6.	Do you incorporate the effectiveness of loss control efforts into the performance evaluation for administrators, department heads, supervisors and managers?	☐ Yes	☐ No
7.	Do you have an internal claim and loss costs analysis system which can be used to prompt necessary loss control program changes on a timely basis?	☐ Yes	☐ No

Applicant Name:

Coverages

Current Coverages & Limits								
	Claims Made / Occurrence	Limit	Deductible / SIR	Annual Aggregate	Maintenance Deductibles	Retroactive Date	Expiring Carrier	Expiring Premium
Property		$	$		$			$
Property Flood		$	$	$	$			
Property Named Wind		$	$		$			
Property Earthquake		$	$	$	$			
Auto Physical Damage		$	$		$			$
General Liability		$	$	$				$
Law Enforcement Liability		$	$	$				$
Automobile Liability		$	$	$				$
E&O / EPLI		$	$	$	$			$
Sexual Harassment		$	$	$	$			
Sexual Abuse		$	$	$	$			
Employee Benefits Liability		$	$	$				$
Workers' Compensation & Employer's Liability		$	$					$
Crime		$	$		$			$
Umbrella / Excess Liability		$	$	$	$			$

Desired Coverages & Limits						
	Claims Made / Occurrence	Limit	Deductible / SIR	Annual Aggregate	Maintenance Deductibles	Retroactive Date
Property		$	$		$	
Property Flood		$	$	$	$	
Property Named Wind		$	$		$	
Property Earthquake		$	$	$	$	
Auto Physical Damage		$	$		$	
General Liability		$	$	$		
Law Enforcement Liability		$	$	$		
Automobile Liability		$	$	$		
E&O / EPLI		$	$	$	$	
EPL Sexual Harassment		$	$	$	$	
EPL Sexual Abuse		$	$	$	$	
Employee Benefits Liability		$	$	$		
Workers' Compensation & Employer's Liability		$	$			
Crime		$	$		$	

Applicant Name:

Exposure Summary

Property – Please attach up-to-date Schedule of Values	
Total Insured Values:	Total Insured Values in Flood Zone A:
Number of Locations:	Total Insured Values in Flood Zone V:
ACV Vehicles:	RCV Vehicles:

General Liability			
Please provide the following if available: Most recent audited financial statements, most recent budget, & most recent actuarial study.			
Population:			
Miles of Streets / Roads:			
Total Revenue:			
Gross Operating Expenditures:			
Net Operating Expenditures:			*Complete Net Operating Section, pg.*
Number of Employees:	Full-Time:		Part-Time:
Utilities (indicate payroll excluding clerical):	Water:	$	*Complete Section on pg.*
	Sewage:	$	*Complete Section on pg.*
	Electric:	$	*Complete Section on pg.*
	Gas:	$	*Complete Section on pg.*
Housing Projects:	Number of Locations:		Number of Units:
Swimming Pools:	Number of Pools:		
	Number of Pools with Lifeguards:		
	Number of Water Parks:		
	Number of Diving Boards:		
Stadiums (5K+ Capacity):	Seating Capacity:		
	Annual Receipts:	$	
Exhibition / Convention Center:	Capacity:		Square Footage:
Principal Uses:			
Special Events:	Are Certificates of Insurance required?		☐ Yes ☐ No
	Are Hold Harmless Agreements from vendors obtained?		☐ Yes ☐ No
Amusement Parks:	☐ Yes ☐ No	If yes, number:	
Ski Facilities:	☐ Yes ☐ No	If yes, number:	
Golf Courses:	☐ Yes ☐ No	If yes, number of courses:	
Watercraft:	☐ Yes ☐ No	If yes, please describe:	
Lakes / Reservoirs:	☐ Yes ☐ No	If yes, please describe:	
Dams / Levees:	☐ Yes ☐ No	If yes, number:	*Complete Section on pg.*
Beaches:	☐ Yes ☐ No	If yes, number:	
Zoos:	☐ Yes ☐ No	If yes, number:	
Parks:	☐ Yes ☐ No	If yes, number:	
Athletic Participants:	☐ Yes ☐ No	If yes, number:	

Applicant Name:

Exposure Summary – cont.

Incidental Medical Malpractice – Please complete section on pg.			
Physicians:	Full-Time:	Part-Time:	Volunteers:
Nurses:	Full-Time:	Part-Time:	Volunteers:
EMTs & Paramedics:			

Law Enforcement Liability – Please complete section on pg.			
Police Officers:	Full-Time, Armed:	Full-Time, Non-Armed:	
	Part-Time, Armed:	Part-Time, Non-Armed:	
	Volunteers:		
Jail Capacity:	Number of Holding Cells:	Number of Detention Cells:	

Automobile Liability	
Private Passenger:	
Police Cars:	
Fire Trucks:	
Vans (no passengers), Light Trucks, Pickups *up to 10K lbs. GVW:*	
Medium Trucks:	
Heavy Trucks:	
Fire Trucks:	
Ambulances:	
Buses:	Capacity 1-8:
	Capacity 9-20:
	Capacity 21-60:
	Capacity 61+:

Applicant Name:

Historical Data

Please provide year-end financial & exposure information for the past five years:

Year	Total Revenue	Gross Operating Expenditure	Net Operating Expenditure	Accumulated Deficit / Surplus	Population	No. of Police	No. of Vehicles	Payroll	No. of Employees
Current									
1st Prior									
2nd Prior									
3rd Prior									
4th Prior									

Applicant Name:

Property Total Insurable Values

Please attach up-to-date Schedule of Values

Total All Buildings:	$
Total All Contents:	$
Business Interruption:	$
Extra Expense:	$
Loss of Rents:	$
Tuition Fees:	$
Owned Builders' Risk:	$
Property in Transit:	$
Accounts Receivable:	$
Valuable Papers & Records:	$
Fine Arts:	$
Mobile Equipment:	$
EDP Equipment:	$
EDP Media:	$
Auto Physical Damage:	$
Underground Property: *(Provide details separately)*	$
Garage Keeper's Legal Liability:	$
Miscellaneous, Please Specify Below:	
	$
	$
	$
	$
	$
Total Insurable Values:	$ 0

Incidental Medical Malpractice

1.	Does the physician, nurse or other healthcare provider carry E&O Professional Medical Malpractice Coverage?	☐ Yes ☐ No
2.	A. Number of Medical Clinics:	
	B. Are there operations performed other than out-patient services?	☐ Yes ☐ No
	If yes, please describe specifically:	
	C. Does The Entity purchase separate insurance for these facilities?	☐ Yes ☐ No
	If yes, please list all carriers and limits:	
	If no, does The Entity contract out medical services for these facilities?	☐ Yes ☐ No

Applicant Name:

Net Operating Expenditures

1.	Total Operating Expenditures:			$
2.	Deductions:	A.	Capital Improvements *(any purchase or improvement of any individual item of personal or real property which is bonded or financed):*	$
		B.	Expenditure for independent Contractor Operations (*where contractor carriers adequate insurance):*	$
		C.	Welfare Benefits (*not administrative costs*):	$
		D.	Expenditures on Exposures which are separately rated below:	
			EMTs / Nurses / Paramedics:	$
			Housing Projects:	$
			Law Enforcement Liability:	$
			Schools or Colleges:	$
			Streets / Highways / Roads:	$
			Utilities:	$
3.	Total Net Operating Expenditures:			$

Automobile Liability

1.	How often are vehicles inspected? ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly				
2.	Are safety inspection records maintained?			☐ Yes	☐ No
3.	Do you have a formal written accident reporting procedure?			☐ Yes	☐ No
4.	Do you have driver-hiring criteria in place?			☐ Yes	☐ No
		A.	MVRs checked on all drivers prior to hire?	☐ Yes	☐ No
		B.	MVRs checked at least annually thereafter?	☐ Yes	☐ No
		C.	Drug / alcohol testing at time of hire?	☐ Yes	☐ No
		D.	Reference checks?	☐ Yes	☐ No
		E.	Road test given prior to hire?	☐ Yes	☐ No
5.	Do you provide a driver training program?			☐ Yes	☐ No
	If yes, please describe:				
	Any other actions taken with regard to driver hiring or training?				
6.	Do you provide safety incentive awards?			☐ Yes	☐ No
	If yes, please describe:				
7.	Are employees, or families of employees, allowed to use company autos for non-business/personal use?			☐ Yes	☐ No
	If yes, please describe:				

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Law Enforcement

1.	Is your department accredited by The Commission on Accreditation for Law Enforcement Agencies?	☐ Yes	☐ No
2.	Do all officers meet state certifying agency minimum training standards?	☐ Yes	☐ No
3.	Describe the relationship with The Entity's Risk Manager and key department heads (i.e. police chief):		
4.	Do you contract law enforcement to any public or private entry?	☐ Yes	☐ No
5.	Are you part of any mutual law enforcement agreements between political subdivisions?	☐ Yes	☐ No
6.	Do all Officers Receive:		
	Firearms Training and Qualification	☐ Yes	☐ No
	Frequency of qualification per year?		
	Impact Weapon Training and Certification	☐ Yes	☐ No
	Chemical Agent (Oleresincapsium) Training and Certification	☐ Yes	☐ No
	Taser Training and Certification	☐ Yes	☐ No
	High Speed Pursuit Driving Training	☐ Yes	☐ No
	Department Policy and Procedure Training	☐ Yes	☐ No
	Constitutional Use of Force Training	☐ Yes	☐ No
7.	Does the department have a policy and procedure manual?	☐ Yes	☐ No
	Date of last overall revision of your policy and procedure manual:		
	Is the manual and subsequent revisions reviewed with and distributed to all personnel?	☐ Yes	☐ No
	Are employees required to sign-off?	☐ Yes	☐ No
	Have the policies and procedures been reviewed by legal counsel?	☐ Yes	☐ No
	If yes, names of counsel:	☐ Yes	☐ No
8.	Does this department have written policies governing the following:		
	Use of Force	☐ Yes	☐ No
	Firearms and Less then Lethal Weapons	☐ Yes	☐ No
	Hot Pursuit	☐ Yes	☐ No
	Sexual Harassment	☐ Yes	☐ No

Jail Operation

1.	Date of last inspection by state or federal corrections officials?		
	The most recent copy of your state or federal department of corrections report is required.		
2.	Year Facility was Built: Year Renovated:		
3.	What is state certified capacity or facility?		
4.	What is the average number of daily inmates?		
5.	What is the average length of stay?		
6.	In the last five years, have there been any suicide attempts resulting in death or serious injury?	☐ Yes	☐ No
	Please provide details of each incident and attach your suicide prevention policy.		
7.	Are jailers on premise at all times?	☐ Yes	☐ No
8.	Are walk-throughs at the facility done every 30 minutes?	☐ Yes	☐ No
9.	Date of last inspection by Fire Inspector?		
10.	Do you have smoke detectors in jail?	☐ Yes	☐ No

Applicant Name:

Jail Operation – Cont.

11.	Are there Audio / Video Systems In:					☐ Yes	☐ No
	Book Areas?	Audio:	☐ Yes	☐ No	Video:	☐ Yes	☐ No
	Sally Port?	Audio:	☐ Yes	☐ No	Video:	☐ Yes	☐ No
	Cell Area?	Audio:	☐ Yes	☐ No	Video:	☐ Yes	☐ No
12.	Do the Jail Operations Manual Include:						
	Please attach policies on items A-E.						
	A. Intake Screening and Classification of Inmates?		☐ Yes	☐ No	Last Updated:		
	B. Strip Searches?		☐ Yes	☐ No	Last Updated:		
	C. Jail Evacuations?		☐ Yes	☐ No	Last Updated:		
	D. Medical Treatment / Sick Call?		☐ Yes	☐ No	Last Updated:		
	E. Suicide I.D. Guidelines and Preventions?		☐ Yes	☐ No	Last Updated:		
13.	Are men and women segregated?					☐ Yes	☐ No
14.	Are youthful offenders (aged 18 & younger) separated from older inmates?					☐ Yes	☐ No
15.	Are prisoners who have committed violent crimes kept separate from those who have been incarcerated for lesser offences?					☐ Yes	☐ No
16.	Is jail under a court order of consent decree? (*If yes, attach copy with any modifications*)					☐ Yes	☐ No

Public Officials Liability

1.	Do you have a written human resources manual?	☐ Yes	☐ No
	If yes, what year was this manual last updated?		
	Please indicate if the manual contains a policy / procedure for the following:		
	Written Application for Employment?	☐ Yes	☐ No
	Legally-Prohibited Discrimination?	☐ Yes	☐ No
	Employee Disciplinary Actions?	☐ Yes	☐ No
	Terminations, Layoffs, Early Retirements?	☐ Yes	☐ No
	Employee Appraisals / Reviews?	☐ Yes	☐ No
	Sexual Molestation / Sexual Harassment?	☐ Yes	☐ No
2.	Is there any employee training provided regarding the above?	☐ Yes	☐ No
3.	Do you have an employee handbook?	☐ Yes	☐ No
	If yes, is it distributed to all employees?	☐ Yes	☐ No
	If yes, is employee signature required?	☐ Yes	☐ No
4.	Employee Turnover for the Last Three Years:		
	Full-Time Employees Hired:	Part-Time Employees Hired:	
	Full-Time Employees Terminated:	Part-Time Employees Terminated:	
5.	What is the advance review procedure for employee termination? Is legal counsel consulted?		
6.	Are there any facts or circumstances that may result in employment-practice claims being made against you? If yes, please provide a listing of each instance:	☐ Yes	☐ No

Applicant Name:

Sexual Abuse – General Information

A.	Nature of Custodial Care Exposure		
1.	Describe all positions involving adult-minor interaction (outside of the usual teacher/student, coach/athlete, counselor/student, etc.):		
	Also, describe fully any volunteer activities:		
2.	Overnight Activities?	☐ Yes	☐ No
	If yes, please describe, including dormitories or sleeping facilities:		
3.	Have there been incidents of sexual or physical abuse in connection with your operation?	☐ Yes	☐ No
	If yes, please explain:		
4.	Have there been investigation(s) of your operations by any public authority relating to sexual or physical abuse?	☐ Yes	☐ No
	If yes, please explain:		
5.	The staff breakdown by age of child is: How Many?		
	Child(ren) Younger than 2 Years of Age:	Staff Member(s):	
	Child(ren) 2-3 Years of Age:	Staff Member(s):	
	Child(ren) 4-5 Years of Age:	Staff Member(s):	
	Child(ren) 6-7 Years of Age:	Staff Member(s):	
	Child(ren) 8 Years of Age & Above:	Staff Member(s):	

B. Selection Procedures			
6.	Do you require a written application for all volunteers and employees?	☐ Yes	☐ No
7.	Is there a pre-employment background check conducted for all employees and volunteers?	☐ Yes	☐ No
	If yes, how:		
	Does a Background Check Information Include:		
	A. Personal References?	☐ Yes	☐ No
	B. Police Record Check?	☐ Yes	☐ No
	C. Child Abuse Register?	☐ Yes	☐ No

Applicant Name:

Sexual Abuse – General Information – Cont.

8.	Do you use any form of psychological profiling or abuse screening techniques?	☐ Yes	☐ No
	If yes, please describe:		

Sexual Abuse – Controls

A. Documented Policy / Procedure Manual			
1.	Do you have a written procedural manual that contains:		
A.	A commitment to child safety?	☐ Yes	☐ No
B.	A child protection policy with assigned responsibilities and accountabilities?	☐ Yes	☐ No
C.	Procedures to be followed in the event of an allegation?	☐ Yes	☐ No
D.	Restrictions on one-to-one activities?	☐ Yes	☐ No
E.	Procedures to be followed in the event of an allegation?	☐ Yes	☐ No
F.	Are rules concerning sexual and physical abuse in place and communicated?	☐ Yes	☐ No
G.	Corporal punishment policy?	☐ Yes	☐ No

B. Employee and Volunteer Training			
2.	Do you have an Orientation Program which all staff members and volunteers are required to complete?	☐ Yes	☐ No
3.	Does the Orientation Program include any of the following:		
A.	A review of the facilities' policies?	☐ Yes	☐ No
B.	Abuse recognition and response?	☐ Yes	☐ No
C.	Rules and procedures for child protection?	☐ Yes	☐ No
D.	Handbooks and documentation of training courses completed?	☐ Yes	☐ No
E.	Informing new employees/volunteers there is zero tolerance for sexual/physical abuse?	☐ Yes	☐ No
F.	Probationary/observation period for new employees/volunteers?	☐ Yes	☐ No
4.	Do you offer any on-going or repetitive training for existing employees / volunteers?	☐ Yes	☐ No
5.	Are the following rules enforced? **(All Items must be completed.)**		
A.	Two Person Rule – No adults are alone with a child.	☐ Yes	☐ No
B.	Transportation is done by two adults, or very strict time and routes which are enforced.	☐ Yes	☐ No
C.	Child custody is pre-established for pickup and visits.	☐ Yes	☐ No
D.	Secret organizations, exclusive clubs, etc. are not tolerated.	☐ Yes	☐ No
E.	Overnight activities are clearly planned and approved by management. Adequate number of pre-approved staff / volunteers, no single adult / child shared sleeping accommodations.	☐ Yes	☐ No
F.	Off premises activities are only done with two or more prepared staff / volunteers.	☐ Yes	☐ No
G.	All areas are checked on an unannounced basis during each week.	☐ Yes	☐ No
H.	No child(ren) left alone without any adult supervision.	☐ Yes	☐ No
6.	Are unannounced parental visits and program involvement encouraged?	☐ Yes	☐ No
7.	Is there a "buddy" system in place for children?	☐ Yes	☐ No
8.	Describe your Complaint Handling Procedures: *(include investigation, documentation, and action steps)*		
	Are they displayed prominently?	☐ Yes	☐ No

Applicant Name:

Sexual Abuse – Controls – Cont.

B. Employee and Volunteer Training – Cont.

9. What procedures have been instituted to prevent reoccurrence of previous events?

Other Insurance

10. Do you have any other insurance in place (i.e. professional coverage) which would respond to sexual and physical abuse claims? ☐ Yes ☐ No

If yes, please describe:

Sexual Harassment

Please read end statement carefully.

A. General Information

List the Five Sites with the Greatest Number of Employees:

1.

2.

3.

4.

5.

Are there any foreign operations? ☐ Yes ☐ No

Coverage Desired (if different from expiring):

Limits of Liability:

Self-Insured Retention:

Has any insurer ever canceled or non-renewed this type of coverage? ☐ Yes ☐ No

If yes, please explain:

B. Loss History

Please provide a summary of a minimum of five years of ground up losses for all sexual harassment claims, both State and Federal, Civil and Administrative in the space below.

Date of Claim	Claimant Name	Nature of Claim	Defense Amount	Indemnity Amount	Reserve, If Open	Current Status

Applicant Name:

Sexual Harassment – Cont.

B. Loss History – Cont.		
Are you aware of any facts/incidents/circumstances which may result in claims being made against you?	☐ Yes	☐ No

C. Employees
Number of Full-Time Employees:
Number of Part-Time Employees:

D. Claims Handling		
With respect to claims incidents, etc. do you have a written procedure for obtaining information?	☐ Yes	☐ No
If yes, please attach a copy.		

E. Risk Management		
1. Does the applicant have a Human Resources or Personnel Department?	☐ Yes	☐ No
If no, please describe handling of this function:		
2. Does the applicant have a Sexual Harassment policy? If yes, please attach a copy.	☐ Yes	☐ No
3. Does the policy include a clear and open reporting procedure?	☐ Yes	☐ No
4. Is the policy "Zero Tolerance"?	☐ Yes	☐ No
5. Is the policy understandable – clear and concise?	☐ Yes	☐ No
6. Is training provided to all supervisory personnel?	☐ Yes	☐ No
7. Is training documented in their supervisory file?	☐ Yes	☐ No
8. Does senior management support policy?	☐ Yes	☐ No
9. Is the policy disseminated to all employees?	☐ Yes	☐ No
10. Are new employees provided with a copy of the policy at orientation?	☐ Yes	☐ No
11. Is training on policy offered to all employees?	☐ Yes	☐ No
12. Is training documented in their personnel files?	☐ Yes	☐ No
13. Has legal counsel reviewed the policy?	☐ Yes	☐ No
If no, please describe or provide separately the review process:		

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Schools

1. Description of School:

2. ☐ Public Institution ☐ Private Institution

3. Average Daily Attendance:

Preschool:	
Kindergarten – 8th Grade:	
High School:	
Vocational:	
College Full-Time:	
College Part-Time:	
Graduate or Professional:	

4. Number of Faculty or Staff Members:

5. Total Square Footage of Campus Building (College/Universities Only):

Please Provide Total Daily Attendance Count for the Past Five Years:

Term	Average Daily Attendance

6. Separately Rated Classifications:

Classification - Total No. Of	Exposure	Classification - Total No. Of	Exposure
Physicians / Nurses / EMTs		**Restaurants / Commissaries**	
Physicians:		Food Receipts:	
Nurses:		Liquor Receipts:	
Student Nurses:		**Day Care Operations**	
EMTs:		Children Supervised:	
Stadium / Bleachers		Locations:	
Facilities:		Supervisors:	
Seating Capacity:		**Swimming Pools**	
Stadium Receipts:		Number of Pools:	

7. Other Exposures:

Classification	Exposure?	Coverage Desired?	If yes, how many?
Beaches of Lakes	☐ Yes ☐ No	☐ Yes ☐ No	
Watercraft	☐ Yes ☐ No	☐ Yes ☐ No	
Hospitality or Clinics	☐ Yes ☐ No	☐ Yes ☐ No	
Athletic Programs	☐ Yes ☐ No	☐ Yes ☐ No	
Radio Stations	☐ Yes ☐ No	☐ Yes ☐ No	

Applicant Name:

Schools – Cont.

7. Other Exposures: - Cont.				
Publishing Activities	☐ Yes ☐ No	☐ Yes ☐ No	
Joint Venture Projects	☐ Yes ☐ No	☐ Yes ☐ No	
Charter Schools	☐ Yes ☐ No	☐ Yes ☐ No	
Students in Practicum	☐ Yes ☐ No	☐ Yes ☐ No	
Police / Security Force	☐ Yes ☐ No	☐ Yes ☐ No	

Utilities

A. Gas Utility – Local Distribution				
1. Total Number of Miles of Gas Pipeline:				
2. Are repair / maintenances records maintained?				☐ Yes ☐ No
3. Is the insured responsible for the maintenance and repair of these pipelines?				☐ Yes ☐ No
4. Is there a comprehensive plan for replacing of aging distribution lines?				☐ Yes ☐ No
5. Are the main shut-off valves and regulating controls indicated?				☐ Yes ☐ No
6. Does the insured obtain additional insured status on the contractor's policy?				☐ Yes ☐ No

B. Electric Utility				
1. Totals Values:				
2. Is the utility operated by the insured?				☐ Yes ☐ No
3. Does the utility provide electrical distribution to other communities?				☐ Yes ☐ No
If yes, please describe:				
4. Does the utility participate in a regional power pool?				☐ Yes ☐ No
5. Are all distribution lines owned by the insured?				☐ Yes ☐ No
6. Turbines:	Size:	Age:	Fuel:	
7. Generators:	Size:	Age:	Fuel:	
8. Number of Substations:				
9. Fenced and secured?				☐ Yes ☐ No
10. Equipped with warning signs?				☐ Yes ☐ No
11. Do they include dates of major repairs and replacements?				☐ Yes ☐ No
12. Are main shut off valves and regulating controls indicated?				☐ Yes ☐ No
13. Is there a plan in place for the replacement of aging facilities and/or distribution lines?				☐ Yes ☐ No
14. Is servicing and maintenance work subcontracted?				☐ Yes ☐ No
If yes, does the insured obtain additional insured status on the contractors policy?				☐ Yes ☐ No
15. Have there been any interruptions in service during the past seven years?				☐ Yes ☐ No
If yes, please explain:				

Applicant Name:

Water Utility / Wastewater Treatment

1. Number of Users:
   - Residency:
   - Commercial:
   - Industrial:
2. Gallons Per Year:
3. Mile of Pipe:
4. Type of Pipe Used:
5. Annual Payroll (excluding Clerical):
6. Percentage of Work, such as Laying of Water Lines, etc., that is:
   - Undertaken directly by Entity:
   - Performed by Independent Contractors:
7. Source of Water Supply:
8. Age of System:
9. Date Upgraded:
10. How often is drinking water tested?
    - By Whom:
11. Does entity have water supply tanks? ☐ Yes ☐ No

Construction	Type	Capacity (gal)	Date Last Inspected

12. Type of public protection around the tank base(s) (fencing, lighting, aircraft warning lights, run-off channels, etc.):

13. Are tanks inspected by qualified engineers? ☐ Yes ☐ No
    - By Whom:
14. Does the system comply with current local and federal standards for hygiene and metals? ☐ Yes ☐ No
15. Has the system ever been cited or fined for non-compliance with required standards? ☐ Yes ☐ No
    - If yes, please provide details, copy of non-compliance notice(s) and action(s) taken to correct problem(s).
16. Is water provided to neighboring entities? ☐ Yes ☐ No
    - If yes, please describe:
17. Total Number of Employees:

Applicant Name:

Dam / Levee / Dike

1.	Type of Structure (Dam, Levee, or Dike):	
2.	Hazard Code (1-5):	
3.	Who is responsible for inspections?	
	How often are inspections performed?	
	How are inspections documented?	
4.	Name of Structure:	
5.	Construction (Cement, Earthen, etc.):	
6.	Age of Structure:	
7.	What are the structure dimensions?	
	Acres:	
	Acre Feet:	
	Capacity:	
	Height:	
8.	How is the water level controlled?	
9.	Who has ultimate responsibility for maintaining water level?	
	Who has ultimate responsibility for opening gates during flood conditions?	
10.	How are gates operated?	
11.	Was this structure constructed under the direction of your Public Entity?	☐ Yes ☐ No
	If no, please describe:	
12.	Does the entity have an emergency notification plan? If yes, please attached plan.	☐ Yes ☐ No
13.	Describe downstream exposures in detail (include distance from structure):	

Please attach copies of most current engineering and/or inspection reports.

Loss History

Please provide up to ten years prior loss history as outlined below. Losses must be shown from first dollar and include open and closed claims.

1. Does the Insured reserve only to retention level? If yes, excess claims information must be provided.	☐ Yes ☐ No
2. If losses are not broken out by General Liability, Law Enforcement Liability and Public Officials Liability, please confirm that these are all included in the information you have provided?	☐ Yes ☐ No

Attach Company Loss Runs Including:

- **Date of Loss**
- **Description of Claim / Injury**
- **Total Incurred Amounts**
- **Paid and Reserves Amounts**
- **Line of Business (GL, AL, PD, SB, PL)**

Applicant Name:

Loss History – Cont.

Losses at 50% (or more) of the proposed SIR for at least the past SIX years:

Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						
Coverage Type	Policy Year Start Date	Policy Year End Date	Paid	Reserve	Ground Up Total	Open / Closed
Brief Description:						

If more, please attach separate page.

Applicant Name:

Third Party Administrators Application

1. Please provide name, address, phone number and key contact of the proposed claim handler:				
Contact Name:				
Company Name:				
Address:				
Street	*City*	*State*	*Zip*	*County*
Phone:				

2. Please list the names, experience levels and authority levels of the claims handling staff:		
Name	**Experience**	**Authority Level**

3.	Who is responsible for reporting claims to the excess carrier?		
4.	Are reserves established for each reported claim?	☐ Yes	☐ No
	If no, please explain:		
5.	Describe Method Utilized in Setting Reserves:		
	Case by Case:		
	Formula:		
	Please explain:		
6.	Who establishes the reserves?		
7.	Are you in compliance with GASB 10?	☐ Yes	☐ No
8.	Describe Your Claim System:		
	Manual:		
	Automated:		
	If automated, is software internally-programmed?	☐ Yes	☐ No
	If automated, is software vendor-programmed?	☐ Yes	☐ No
9.	If vendor-programmed, please provide name of vendor:		
10.	How often are claim reports generated?		
11.	Do your claim reports include details on the current status of each claim, as well as the paid amount, incurred amount and description of loss?	☐ Yes	☐ No
12.	How is litigation handled?	☐ Yes	☐ No
	Legal Staff?	☐ Yes	☐ No
	Independent Counsel?	☐ Yes	☐ No
	Both?	☐ Yes	☐ No
13.	Are all claim files and reports centralized and coordinated by one individual?	☐ Yes	☐ No

Applicant Name:

Checklist

Have you completed all the applicable sections?		
In particular, please ensure that you have supplied the following:		
- General Information	☐ Yes	☐ No
- Loss Control	☐ Yes	☐ No
- Coverage	☐ Yes	☐ No
- Exposure Summary	☐ Yes	☐ No
- Historical Data	☐ Yes	☐ No
- Net Operating Expenditures & Budget	☐ Yes	☐ No
- Police	☐ Yes	☐ No
- E&O	☐ Yes	☐ No
- Sexual Harassment / Abuse	☐ Yes	☐ No
- Safety Manual	☐ Yes	☐ No
- Executive Summary	☐ Yes	☐ No
- Competition Details	☐ Yes	☐ No
Is it a Bid?	☐ Yes	☐ No
Retail Broker working for a Fee or Commission?	☐ Yes	☐ No
	☐ Yes	☐ No

Signature

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 the person to criminal and civil penalties.

Completion of this questionnaire creates no obligation upon the applicant to accept insurance or upon Markel to offer insurance. However, in the event that any insurance offering is accepted by the applicant or is issued by Markel, this questionnaire will form the basis for the acceptance and insurance.

Signature	*Company*
Printed Name	*Street Address*
Title	*City, State, Zip*