

Sexual & Physical Misconduct Addendum

Instructions – PLEASE READ:

1. Please type or print clearly and complete all questions.
2. This is an addendum, to be completed in conjunction with a main form application.
3. This application must be completed, dated and signed by a Principal of the Applicant.

Requested Attachments:

1. Currently valued sexual misconduct (sublimit or standalone policy) loss runs - minimum of prior FIVE years.
2. Copy of Sexual & Physical Abuse Prevention Policies, Protocol, & Employee Handbook

1. Applicant (first named insured):

2. Additional named insureds (please include subsidiaries for which coverage is sought under this policy):

Section A: Individuals with Patient & Client Exposure

3. Complete the following chart for individuals with exposure to patients & clients on behalf of the applicant:

Type	Count	Male	1:1 Exposure	Annual Turnover
Employee		%	%	%
Contractor		%	%	%
Volunteer		%	%	%
Other (describe)		%	%	%

Section B: Hiring and Training Practices

4. As a part of training or hiring, does the applicant currently:

	Yes	No
Conduct national criminal background checks for all employees, contractors, and volunteers upon hire / engagement?	<input type="checkbox"/>	<input type="checkbox"/>
Conduct national criminal background checks for all employees, contractors, and volunteers annually?	<input type="checkbox"/>	<input type="checkbox"/>
Conduct national sexual offender registry checks for all employees, contractors, and volunteers upon hire / engagement?	<input type="checkbox"/>	<input type="checkbox"/>
Conduct national sexual offender registry checks for all employees, contractors, and volunteers annually?	<input type="checkbox"/>	<input type="checkbox"/>
Distribute sexual abuse prevention policies/ handbooks for employees & volunteers, at onboarding?	<input type="checkbox"/>	<input type="checkbox"/>



Conduct a formal mandatory abuse prevention and education program?	<input type="checkbox"/>	<input type="checkbox"/>
Require staff to re-complete abuse prevention training on an annual basis?	<input type="checkbox"/>	<input type="checkbox"/>
Conduct personal and professional reference checks prior to hire / engagement?	<input type="checkbox"/>	<input type="checkbox"/>
Prohibit the hiring of staff with any prior abuse allegations?	<input type="checkbox"/>	<input type="checkbox"/>

Section C –Vulnerable Person Identification

5. Describe the applicant’s patient and client base below: (does not have to equal 100%)

- | | | |
|---|---|---|
| <input type="checkbox"/> % Ages 0-10 | <input type="checkbox"/> % Ages 11-18 | <input type="checkbox"/> % Ages 75+ |
| <input type="checkbox"/> % DD/ID | <input type="checkbox"/> % Economically Disadvantaged | <input type="checkbox"/> % Medication/Anesthesia Impaired |
| <input type="checkbox"/> % Mental Health Disorder | <input type="checkbox"/> % Substance Abuse Disorder | <input type="checkbox"/> % Unaccompanied Minor |
| <input type="checkbox"/> % Other (describe) | | |

Section D– Best Practices, Policies and Culture

6. Briefly describe the applicant’s culture and approach to sexual and physical abuse prevention:

7. Please indicate if elements of the applicant’s sexual and physical abuse prevention policies and practices are currently in place below:

	Yes	No
Does applicant have a disseminated checklist of heightened abuse risk indicators?	<input type="checkbox"/>	<input type="checkbox"/>
Are there written policies addressing the prevention of abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Does applicant utilize a Zero Tolerance statement for any sexual or physical abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Does the applicant allow for 1:1 encounters with patients and clients?	<input type="checkbox"/>	<input type="checkbox"/>
If 1:1s are allowable, are doors kept open or is there an unobstructed window?	<input type="checkbox"/>	<input type="checkbox"/>
Does the applicant prohibit romantic relationships with current and/or former clients or patients?	<input type="checkbox"/>	<input type="checkbox"/>
Does the applicant's policy address acceptable electronic communication including email, chat, social media, video call with patients and clients?	<input type="checkbox"/>	<input type="checkbox"/>
Does the applicant have a written policy that defines inappropriate and appropriate conduct and displays of affection?	<input type="checkbox"/>	<input type="checkbox"/>
For any massage or spa exposure : does the applicant use proper draping technique?	<input type="checkbox"/>	<input type="checkbox"/>
For any massage or spa exposure : are there panic buttons in the rooms?	<input type="checkbox"/>	<input type="checkbox"/>
For any massage or spa exposure : does the applicant allow the client to choose their masseuse and or their gender?	<input type="checkbox"/>	<input type="checkbox"/>
For services provided via physical touch/exam : Is verbal touch consent obtained from the patient?	<input type="checkbox"/>	<input type="checkbox"/>



For services provided via physical touch/exam : Does the provider describe the touch and reason in advance?	<input type="checkbox"/>	<input type="checkbox"/>
For services provided via physical touch/exam : Is more than one provider or staff present in the room?	<input type="checkbox"/>	<input type="checkbox"/>
Does the applicant have written policies for response to allegations of abuse or inappropriate conduct?	<input type="checkbox"/>	<input type="checkbox"/>
Does the applicant have a written crisis management plan including abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Does the applicant provide a method for anonymous reporting of abuse or inappropriate conduct?	<input type="checkbox"/>	<input type="checkbox"/>

8. Please indicate if the following physical abuse prevention policies and practices are currently in place:

	Yes	No
In the event of potential violence/ harm does the applicant use a verbal crisis de-escalation practice?	<input type="checkbox"/>	<input type="checkbox"/>
Is there an anti-restraint policy in place?	<input type="checkbox"/>	<input type="checkbox"/>
Does the applicant prohibit corporal punishment?	<input type="checkbox"/>	<input type="checkbox"/>

9. Reporting & Response:

Describe the applicant’s protocol for investigation, response, & reporting of abuse allegations:

10. Supervision and Oversight:

Does the applicant’s patient care location include:	Yes	No
Designated security personnel	<input type="checkbox"/>	<input type="checkbox"/>
Gated property	<input type="checkbox"/>	<input type="checkbox"/>
Locked Doors/ internal key fobs	<input type="checkbox"/>	<input type="checkbox"/>
Check in and check out desk	<input type="checkbox"/>	<input type="checkbox"/>
Guards between different gender wings	<input type="checkbox"/>	<input type="checkbox"/>
Guards between detox unit and other units	<input type="checkbox"/>	<input type="checkbox"/>
Rooms with unobstructed windows for observation	<input type="checkbox"/>	<input type="checkbox"/>
Interior cameras	<input type="checkbox"/>	<input type="checkbox"/>
Exterior cameras	<input type="checkbox"/>	<input type="checkbox"/>
How long is camera footage saved?		



Does the applicant's supervision protocol include:	Yes	No
Randomized drop in/ visit	<input type="checkbox"/>	<input type="checkbox"/>
Separate and secure sleeping areas	<input type="checkbox"/>	<input type="checkbox"/>
Age separation	<input type="checkbox"/>	<input type="checkbox"/>
Gender separation	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual capacity/ disability separation	<input type="checkbox"/>	<input type="checkbox"/>

Section 7 – History

11. Is the applicant aware of any employees, contractors, or volunteers with a prior history of sexual or physical misconduct or allegations of sexual or physical misconduct? Yes No

Please describe the incident(s) and dates to include the applicant's investigation and response plan:

12. Prior Sexual Misconduct (sublimit or standalone policy) insurance history: No prior coverage:

Year	Standalone/Package	Carrier	Limits	Deductible	Retro Date	Premium

13. Please provide details of applicant's total aggregate losses, from the 1st dollar. No Losses

Policy Period	Insurer	Number Of Claims	Total Cost Incurred



a. Any potential claim(s)/known incident(s) not yet reported? Please explain:

Yes No

[Redacted area for question a]

b. Has any **claim or suit** for a sexual and/or physical misconduct incident ever been made against applicant or its employees/ volunteers/contractors? Please explain:

Yes No

[Redacted area for question b]

SIGNATURE SECTION

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT TO SIGN THIS APPLICATION ON THE APPLICANT'S BEHALF AND DECLARES THAT THE STATEMENTS CONTAINED IN THE INFORMATION AND MATERIALS PROVIDED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION AND THE UNDEWRITING OF THIS INSURANCE ARE TRUE, ACCURATE AND NOT MISLEADING. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION AND ANY OTHER INFORMATION AND MATERIALS SUBMITTED TO THE INSURER IN CONNECTION WITH THE UNDERWRITING OF THIS INSURANCE ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY. FOR NORTH CAROLINA APPLICANTS, SUCH APPLICATION MATERIALS ARE PART OF THE POLICY, IF ISSUED, ONLY IF ATTACHED AT ISSUANCE.

THIS APPLICATION AND ALL INFORMATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY AS IT DEEMS NECESSARY REGARDING THE INFORMATION AND MATERIALS PROVIDED TO THE INSURER IN CONNECTION WITH THE UNDERWRITING AND ISSUANCE OF THE POLICY.

THE APPLICANT AGREES THAT IF THE INFORMATION PROVIDED IN THIS APPLICATION OR IN CONNECTION WITH THE UNDERWRITING OF THE POLICY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

I HAVE READ THE FOREGOING APPLICATION FOR INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO, AND RHODE ISLAND APPLICANTS: 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.

NOTICE TO COLORADO APPLICANTS: 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.

NOTICE TO CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

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NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO KANSAS APPLICANTS: AN ACT COMMITTED BY 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, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO 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.

NOTICE TO MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON APPLICANTS: 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.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR 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.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD THE INSURER BY SUBMITTING AN APPLICATION CONTAINING A FALSE STATEMENT AS TO ANY METEERIAL FACT MAY BE VIOLATING STATE LAW.

NOTICE TO KENTUCKY, NEW JERSEY, OHIO, AND PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIMS 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.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIMS 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. IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS (\$5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signed*: _____ Date: _____

Print Name: _____ Title: _____
(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa, please provide the Insurance Agent's name and signature only.

Agent's Printed Name:

Florida Agent's License Number:

Agent's Signature:

*If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a keypad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

Electronic Signature and Acceptance – Authorized Representative

Electronic Signature and Acceptance - Producer