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PREGNANCY CENTER APPLICATION

Applicant Name: ______________________________

Address: ______________________ City/St: ______________ Zip: ________

Contact Name: ________________ Telephone #: ____________ FEIN #: ____________

Website: ______________________ Email: ______________________

Current Carrier: ______________________ Pol # ____________ Eff Date: ________

FOR PROFIT ☐ // NON-PROFIT ☐

Year Business Established ________ Years Under Present Executive Director ________

Prior Insurance: How Many Years? 1 ☐ 2 ☐ 3 ☐ 4 ☐ More ☐

Indicate all Programs administered by the Insured (check all that apply):

Professional Services Offered:

- ☐ Pregnancy Testing (other than self administered urine)
- ☐ Ultrasound/Sonogram to Determine Pregnancy
- ☐ Ultrasound – Medical Professional Diagnosis
- ☐ Medical Professional Diagnosis
- ☐ Adoption Services
- ☐ STD Testing
- ☐ RU486 Reversal/Abortion Reversal
- ☐ Other ______________________

Counseling Services Offered:

- ☐ Caring Peer Counseling
- ☐ Materials Assistance (diapers, clothing, etc)
- ☐ Family Planning
- ☐ Information/Education/Referral Services
- ☐ Parenting Classes (Mom & Dad)
- ☐ Other ______________________

1) Total Assets ____________ 2) Annual Revenues ____________ 3) Total # Employees F/T _____ PT _____

4) Do you have all required licenses? Yes ☐ No☐ Are they current? Yes ☐ No☐

5) Has any license ever been lost, revoked or suspended? Yes ☐ No☐ If yes, please explain:

____

6) Do you sell any goods or services to others? Yes ☐ No☐ If yes, describe: ______________________

7) Do you have a plan for medical emergencies? Yes ☐ No☐

8) Do you have any owned business autos? Yes ☐ No☐

9) Do you hire vehicles? Yes ☐ No☐

If yes, what types of vehicles do you hire? ______________________

10) Annual number of vehicles hired: ________ Annual cost of hire: ____________

11) How many employees/volunteers drive personal vehicles for business use: regularly? ______ occasionally? ______

a. Do you obtain proof of insurance for anyone driving for business purposes? Yes ☐ No☐
b. Do you update these records at least semi-annually? Yes ☐ No☐
c. Do you require at least $100,000 in minimum limits? Yes ☐ No☐

12) Total Payroll: ____________

PROPERTY

Address: ______________________ Building Description: ______________

Construction ____________ # of Stories ___ Total Sq. Ft.: ______ Monitored Security System: Yes ☐ No☐

Own ☐ Lease ☐ Building Value: ______________ Distance to Fire Station: ______ miles

Content Value: ______________

Does any property leave the office premise? Yes ☐ No☐

Please provide itemized list of portable equipment that is taken off premise (i.e. laptops, portable sonograms, etc.)

Sonogram Value: ______________ Number of Units: ________

PROPERTY (Continued)

Address: ______________________________ Building Description: ______________

Construction ___________ # of Stories ___ Total Sq. Ft.: ________ Monitored Security System: Yes ☐ No☐

Own ☐ Lease ☐ Building Value: ___________ Distance to Fire Station: _______ miles

Content Value: ___________ Please provide itemized list of portable equipment that is taken off premise (i.e. laptops, portable sonograms, etc.)

Does any property leave the office premise? Yes ☐ No☐

Sonogram Value: ___________ Number of Units: __________

Address: ______________________________ Building Description: ______________

Construction ___________ # of Stories ___ Total Sq. Ft.: ________ Monitored Security System: Yes ☐ No☐

Own ☐ Lease ☐ Building Value: ___________ Distance to Fire Station: _______ miles

Content Value: ___________ Please provide itemized list of portable equipment that is taken off premise (i.e. laptops, portable sonograms, etc.)

Does any property leave the office premise? Yes ☐ No☐

Sonogram Value: ___________ Number of Units: __________

PROPERTY CLAIMS

Have you ever filed any type of claim? Yes ☐ No☐ If yes, please explain:

____

____

____

PROFESSIONAL LIABILITY / ABUSE

Nurses: # of Full Time: _________ # of Part Time ________ # of Volunteers: _________

Nurses Names and Title: ______________________________

Doctors: # of Full Time: _________ # of Part Time ________ # of Volunteers: _________

Doctors Names and Title: ______________________________

Do any serve as Medical Director, Medical Administrator or the Executive Director of the Pregnancy Center? Yes ☐ No☐

Counselors: # of Full Time: _________ # of Part Time ________ # of Volunteers: _________

1) Has your organization ever had in incident which resulted in an allegation or claim of sexual abuse? Yes ☐ No☐

If Yes, Please describe ______________________________

____

2) Do you obtain criminal background checks on all individuals before hiring? Yes ☐ No☐ Volunteers? Yes ☐ No☐

REMARKS

RETROACTIVE DATES FOR CLAIMS MADE COVERAGES

Is your General Liability Insurance currently written on a claims made basis? Yes ☐ No☐ If yes, retro date: _______________

Is your Professional Liability Insurance currently written on a claims made basis? Yes ☐ No☐ If yes, retro date: ____________

Is your Medical Malpractice Insurance currently written on a claims made basis? Yes ☐ No☐ If yes, retro date: ____________

OWNED AUTOMOBILES

1. Year: _________ Make: ______________ Model: ____________________ Liability Only: ☐ Full Coverage: ☐
2. Year: _________ Make: ______________ Model: ____________________ Liability Only: ☐ Full Coverage: ☐

Drivers: Name	Birthdate	State & License #	Violations/Accidents

LIABILITY CLAIMS

Have you ever filed any type of claim? Yes ☐ No☐ If yes, please explain:

____

____

____

DIRECTORS & OFFICERS

Do you currently have coverage? Yes ☐ No☐

Name of Current Carrier: ______________________________ Renewal Date: ____________

Number of Directors: _________ Number of Employees: Full Time: _______ Part Time: ______ Volunteers: _______

DIRECTORS & OFFICERS CLAIMS

Have you ever filed any type of claim? Yes ☐ No☐ If yes, please explain:

____

____

____

WORKERS COMPENSATION

Do you currently have Workers Compensation? Yes ☐ No☐

Name of Carrier: ______________________________ Policy #: ________________ Renewal Date: ______

	# FT	# PT	Annual Payroll
Director/Clerical	_______	_______	_______________
Nurse	_______	_______	_______________
Doctor	_______	_______	_______________

WORKERS COMPENSATION CLAIMS

Have you ever filed any type of claim? Yes ☐ No☐ If yes, please explain:

____

____

____

SPECIAL EVENTS

Do you sponsor any special events? Yes ☐ No☐ If so, please explain:

____

CLAIMS

Have you ever filed any type of claim? Yes ☐ No☐ If yes, please explain:

____

____

____

ADDITIONAL REMARKS

NOTICE TO APPLICANTS:
In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime. This quotation is subject to loss runs within 10 days of binding.

Signature is not required for a quote.

____
APPLICANT'S SIGNATURE (A quote will not be provided without applicant's signature.)

TITLE: ____________________________________ DATE: ______________________

____ DATE: ______________________
AGENT'S SIGNATURE