



Thank you for your trust in PPIB to support you with your Insurance needs. We're thrilled to do business with you and help protect what matters most to you. To get started, please follow these steps:

How to Submit Application

1. Complete Application -- Fill out the required information on the next few pages.
2. Save Application -- Once completed, save a copy to your computer so you can email it.
3. Sign Application -- Ensure it is signed by the business owner, either electronically or printed and signed.
4. Submit Application -- Send signed application to **submissions@ppibcorp.com**.

What to Expect Next?

After receiving your application, we will send you a confirmation email acknowledging receipt.

Within 3-5 business days, one of our insurance experts will reach out to you with any follow-up questions or a quote, depending on the status of your submission.

If you need the quote expedited, please indicate this when you submit your application via email.

If you need further assistance with the application, or have additional questions, please feel free to contact us at:

PHONE:

415.475.4300

877.655.0123

Submissions: submissions@ppibcorp.com

FAX:

415.475.4303

Let's Get Started

Fill Out Application on Next Page



SEXUAL ABUSE AND MOLESTATION (SAM) LIABILITY APPLICATION

SECTION I: GENERAL INFORMATION

1. Applicant Name (First, Last): _____ Phone Number: _____
2. Business Name: _____
3. Email Address: _____ Website: _____
4. Your Mailing Address: _____
City: _____ State: _____ Zip code: _____
5. Main Business Address: _____
City: _____ State: _____ Zip code: _____
6. Business operated as: ☐Corporation ☐LLC ☐Partnership ☐Individual ☐Independent Contractor
7. How long have you been in business? _____
8. Is your business part of a franchise? ☐Yes ☐No If Yes, which one? _____
9. Risk Management Contact Name (First, Last): _____
10. Email Address (Risk Management): _____ Phone Number: _____
11. Is this coverage contractually required? ☐Yes ☐No
12. Do you offer overnight accommodations? ☐Yes ☐No
 - a. If Yes, answer i-iv:
 - i. Are genders separated? ☐Yes ☐No
 - ii. Are ages separated? ☐Yes ☐No
(A) If Yes, what ages are grouped together? _____
 - iii. Are minors supervised at all times? ☐Yes ☐No ☐N/A
 - iv. What is the minor-to-adult ratio during the overnight stays? _____
13. Provide total number of individuals / students / patients / members served annually : _____
14. Do you provide services in the homes of clients? ☐Yes ☐No
15. Are you in compliance with all city, county, and/or state ordinances? ☐Yes ☐No
16. Do all professionals have licenses / certifications for all states where operations are performed? ☐Yes ☐No ☐N/A
17. Please complete the financial data tables below or provide annual income statements and balance sheets for the organization for both this year & last year:

Financial Information	Current Year (20__)	Last Year (20__)
Cash:	\$ _____	\$ _____
Annual Revenue:	\$ _____	\$ _____
Net Income (Loss):	\$ _____	\$ _____
18. Have you merged with any other entity in the past 12 months or are you planning to do so in future? ☐Yes ☐No
 - a. If Yes, please provide details: _____
19. Have there been any significant changes in the operation or scale of the organization within the last 12 months? ☐Yes ☐No
 - a. If Yes, please provide details: _____
20. Have you previously purchased Sexual Abuse and Molestation liability coverage? ☐Yes ☐No
 - a. If Yes, attach a copy of the policy or ask your broker to provide details and answer questions i-ii:
 - i. Retroactive Date (mm/dd/yyyy): _____
 - ii. Has continuous coverage been in force without a gap since the retroactive date provided? ☐Yes ☐No

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SECTION II: ORGANIZATION DETAILS

**** Select All Descriptions that Apply ****

Behavior Health Services

- | | | |
|---|---|--|
| ☐ Addiction Services | ☐ Mental Health Providers / Care | ☐ Therapeutic Camps and Schools |
| ☐ Youth Behavior Modification Facilities | ☐ Other: _____ | |

Business Offices

- | | | |
|---|--|--|
| ☐ Staffing Agencies | ☐ Banks / Investments | ☐ Manufacturers |
| ☐ CPA Audit Forms | ☐ Law Firms | ☐ Retail |
| ☐ Insurance Agencies / Companies | ☐ Other: _____ | |

Child Care Services

- | | | |
|---|--|---------------------------------------|
| ☐ Overnight Camps | ☐ Home Daycare Centers | ☐ Day Camps |
| ☐ Commercial Childcare Centers | ☐ Daycare Centers Inside Other Operations (Gym, Hotels, etc.) | ☐ Other: _____ |

Education

- | | | |
|--|--|--|
| ☐ Homeschool Groups | ☐ Tutoring | ☐ Educational Counseling |
| ☐ Interpreter | ☐ Speech Therapist | ☐ School Nurse |
| ☐ Counselor | ☐ Special Education Advocates | ☐ Fraternity / Sorority Housing |
| ☐ Other: _____ | | |

Events / Entertainment

- | | | |
|---|---|---|
| ☐ Music / Film Industry | ☐ Pyrotechnic Displays | ☐ Comedy Shows |
| ☐ Concerts | ☐ Adult Entertainment Industry | ☐ Birthday Party Entertainment |
| ☐ Conventions / Conference Hosts or Sponsors | ☐ Media Productions (Live or Web Hosted) | ☐ Other: _____ |

Healthcare

- | | | |
|--|---|---------------------------------------|
| ☐ Traveling Nurse | ☐ Physical Therapy | ☐ Sleep Study |
| ☐ Dental Care | ☐ Home Health | ☐ School Nurse |
| ☐ Medical Directors / Lab Directors | ☐ Other: _____ | |

Hospitality

- | | | |
|---|--------------------------------------|---------------------------------------|
| ☐ Hotels / Resorts | ☐ Restaurants | ☐ Other: _____ |
|---|--------------------------------------|---------------------------------------|

Law Enforcement / First Responders

- | | | |
|--|--|---|
| ☐ Detention Centers | ☐ Parole / Probation Offices | ☐ EMT / Paramedics |
| ☐ Fire Departments | ☐ Police Departments / State Troopers | ☐ Other: _____ |

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Leisure

- | | | |
|--|---------------------------------------|--|
| ☐ Casinos | ☐ Theaters | ☐ Agritainment / Agritourism |
| ☐ Campgrounds | ☐ Museums | ☐ Art Installations / Galleries |
| ☐ Amusement Parks / Zoos / Family Fun | ☐ Other: _____ | |

Services

- | | | |
|--|---|---|
| ☐ Electrician | ☐ Massage Parlors / Franchises | ☐ Medical Directors / Lab Directors |
| ☐ Marketing | ☐ Auto Repair / Maintenance | ☐ Roofer |
| ☐ Handyman | ☐ Plumber | ☐ HVAC |
| ☐ General Construction Contractor | ☐ Beauty / Salon / Spas / Medispas | ☐ Other services that travel to home or business |
| ☐ Other: _____ | | |

Social Services

- | | | |
|---|--|--|
| ☐ Homeless Outreach | ☐ CASA Workers / Volunteers | ☐ Senior Centers |
| ☐ Group Homes | ☐ Hospice | ☐ Foster Care / Adoption Services |
| ☐ Assisted Living / Skilled & Nursing Facilities | ☐ Social Referral Agencies or Contractors | ☐ Other: _____ |

Sports / Health Club

- | | | |
|---|---|--|
| ☐ Individual Personal Training | ☐ Swim Clubs | ☐ Dance Studios |
| ☐ Gymnastics / Cheer Studios | ☐ Youth Sports Organizations | ☐ Tennis Club |
| ☐ Gym / Yoga / Pilates Studio | ☐ Fitness Instruction | ☐ Other: _____ |

Technology

- | | | |
|--|---|---|
| ☐ Technical Support Businesses | ☐ Installation and Programmers | ☐ Network Administration |
| ☐ Software & Hardware Development / Sales | ☐ Other: _____ | |

Transportation

- | | | |
|--|--|---|
| ☐ Public Transportation | ☐ Charter Buses | ☐ Limousine Companies |
| ☐ Uber / Lyft Contracts | ☐ Daily School Bus Transportation | ☐ School / Academic Transportation |
| ☐ Other: _____ | | |

Youth Organizations

- | | | |
|---|--|-------------------------------|
| ☐ Boys & Girls Clubs | ☐ Scouts of America | ☐ YMCA |
| ☐ Other: _____ | | |

Non-Profit Organization

- ☐ Provide Name: _____

Religious Organization

- ☐ Provide Name: _____

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SECTION III: STAFF DETAILS

1. Complete the staff grid below:

	Number of Employees, including Temps / Leased (incl. yourself if sole proprietor):	Number of Independent Contractors:	Number of Volunteers:	Percentage of Male Employees:
Total:				

2. Confirm if there are any minors acting as employees, independent contractors, volunteers, or any other staff role for the insured organization. ☐ Yes ☐ No

3. Are any individuals listed above non-US Citizens? ☐ Yes ☐ No If Yes, how many? _____

4. Are any individuals listed above located in a different state or country than your base of operations? ☐ Yes ☐ No

a. If Yes, complete the below:

	States:	Countries:	Indicate # of Staff:

b. If staff are based in more than 5 states and/or countries, please attach a separate schedule.

SECTION IV: RISK MANAGEMENT

Identify the methods used in screening, hiring and training processes for all individuals listed in Staff Details. For any individuals who are minors, use the additional details section to describe any differences in the screening process.

Screening

	Employees	Contractors	Volunteers	Additional Details
1. Prior to working, are the following screened through a National Criminal background check?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
2. Prior to working, are the following screened through the National Sexual Offender Registry?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

a. If repeated, how often? ☐ Never ☐ Quarterly ☐ Semi-Annually ☐ Annually
☐ Other: _____

b. If background check indicates past activity, are they still eligible for employment? ☐ Yes ☐ No

i. If Yes, provide name and detail of any convictions: _____

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Monitoring

1. Identify the mechanisms used to control and monitor access to the facility in day-to-day operations:

- a. Check-in and check-out procedures ☐ Yes ☐ No ☐ N/A Additional Details: _____
- b. Exterior and/or interior cameras ☐ Yes ☐ No ☐ N/A Additional Details: _____
- c. Is the video footage saved? ☐ Yes ☐ No ☐ N/A Additional Details: _____
- i. If Yes, for how long? _____

2. Are one-on-one encounters permitted with clients?

☐ Yes ☐ No

a. If Yes, answer i-v:

- i. How often these situations occur? _____
- ii. Who these encounters involved? _____
- iii. Where would they take place? _____
- iv. How are the interactions monitored? _____
- v. Are there written procedures defining how to manage this type of risk? ☐ Yes ☐ No

b. If No, are there written policies in place that prohibit one-on-one encounters?

☐ Yes ☐ No

Training

Do all individuals participate in training that addresses the following?

	Employees	Contractors	Volunteers	Additional Details
1. The organization's policies related to preventing abuse?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
2. How to maintain appropriate boundaries with vulnerable populations?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
3. What constitutes appropriate and inappropriate interactions across all forms of communication (physical, verbal, written, and electronic)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
4. How to respond to allegations of incidents or abuse, including mandated abuse reporting requirements?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
5. How to respond to incidents of inappropriate behavior or sexual activity between vulnerable populations?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

6. Are there specific written policies that apply to all individuals that define the following?

- a. What abuse and/or molestation is ☐ Yes ☐ No
- b. A zero tolerance for abuse and molestation ☐ Yes ☐ No

7. If the training or policies only apply to some individuals, but not all, explain:

	Employees	Contractors	Volunteers	Additional Details
8. Do you require the individuals to sign a written acknowledgement of receipt, review and comprehension of your abuse or molestation policies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

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9. Who conducts the abuse prevention training? ☐ Internal Staff ☐ External Company
- a. How often is training repeated? ☐ Never ☐ Quarterly ☐ Semi-Annually ☐ Annually
☐ Other: _____
- b. Provide when policies were last reviewed: ____/____/____ Last updated: ____/____/____
- c. Is there a specific person or department that administers, establishes, monitors and enforces policies and procedures across all locations and departments? ☐ Yes ☐ No

Reporting

1. Do you have formal reporting procedures for individuals to raise complaints, grievances, and/or suspected abuse? ☐ Yes ☐ No
- a. If Yes, how is this communicated? ☐ Website ☐ Handbook ☐ Posting Notice
☐ Other: _____
2. Is anonymous reporting an option? ☐ Yes ☐ No

SECTION V: HISTORY

Note – ALL questions must be answered. Failure to disclose claims history could invalidate coverage.

1. Have you or your business ever had an insurance policy cancelled or non-renewed for this type of coverage? ☐ Yes ☐ No
- a. If Yes, identify the provider and explain:
2. Have you or your business had any sexual misconduct claims in the past 10 years? ☐ Yes ☐ No
- a. If Yes, identify the provider and explain:
3. Are you or anyone in your business aware of any facts, incidents, circumstances, or allegations that may result in claims being made against you or anyone listed in the Staff Details section? ☐ Yes ☐ No
- a. If Yes, provide details:
4. Have you or any personnel currently seeking coverage been involved in an allegation or claim relating to sexual abuse or been transferred in or out of your school, parish / diocese, branch, or corporate location because they were involved, suspect, or a complaint was made regarding an allegation of sexual abuse? ☐ Yes ☐ No
- a. If Yes, provide details:
5. In the past 10 years, has any person listed in the Staff Details section or officers been terminated for cause related to sexually abusive behavior? ☐ Yes ☐ No
- a. If Yes, provide details:

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SECTION VI: ADDITIONAL INSURED

If this Section does not apply, Check Here ☐

1. Do you have an Additional Insured (AI) who contractually needs to be listed on the policy? ☐ Yes ☐ No
- a. AI Name: _____
- b. Address: _____
- c. Does the AI require the following? ☐ Primary / Non-Contributory Wording ☐ Waiver of Subrogation
- d. Interest of Additional Insured? ☐ Contract Holder ☐ Permitting Office ☐ City / Government Agency
- ☐ Other: _____

SECTION VII: ATTESTATION

On Behalf of ALL Operations, I confirm:

1. No insurance will be offered for any operations / activities unless specifically endorsed on to the policy and a premium is paid.
2. I understand and agree this Application and any supplements attached hereto will be relied upon for the insurance policy.
3. I understand and agree that failure to provide true and accurate response to the forgoing questions may result in the voiding of the insurance issued in reliance on this application and/or denial of claims under the policy issued.
4. I authorize and consent to investigation of information of my business including authorization to every person or entity, public or private, to release the company, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application but shall include any other sources of information deemed relevant by the Company as may be authorized by law.
5. If I am aware of any claim or incident arising from any time prior to today, I must advise underwriters at this time.
6. The liability policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.
7. This insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

(For a full list of terms and conditions, consult the policy forms)

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS PRIOR TO BINDING (60 DAYS FOR RENEWALS).

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

COVERAGE BECOMES EFFECTIVE WHEN REVIEWED AND ACCEPTED BY THE INSURANCE COMPANY.

Must provide loss runs for all prior coverage up to 10 years ago.

Owner / Managing Member / Corporate Officer Signature

Date Signed

Title

Human Resources Representative Signature

Date Signed

Title

Requested Effective Date

Liability Limit Requested:

☐ \$500K/\$500K ☐ \$1M/\$1M ☐ Other: _____

**POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE**

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, **as defined in Section 102(1) of the Act, as amended:** The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2027, the date on which the TRIA Program is scheduled to terminate, or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 80% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A USD100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS USD100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED USD100 BILLION, YOUR COVERAGE MAY BE REDUCED.

THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

	(ACCEPT) I hereby elect to purchase coverage for acts of terrorism for a prospective premium of USD.....
	(DECLINE) I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

Policyholder/Applicant's Signature

Carrier

Print Name

Policy Number

Date