RISK strategies
Academic HealthPlans

Sexual Misconduct Liability Coverage Request Supplemental Questionnaire

TO AVOID PROCESSING DELAYS, PLEASE:

1. Complete all sections (print legibly)
2. Remit completed questionnaire with payment

GENERAL INFORMATION

Named insured (as it appears on your Member Certificate):_____

Policy number (as it appears on your Member Certificate): _____

Mailing address: _____

NY Applicants must provide a street address. PO Boxes cannot be accepted.

City: _____ State:_____ Zip:_____

Contact name: _____ Phone: (_____) _____

Cell: (_____) _____ Fax: (_____) _____

E-mail:_____ Website: _____

DATES

Coverage will begin the day after coverage is bound or on a later date you specify below. Coverage will expire on the same day as your RPG commercial general liability program coverage.

❍ Start my coverage on this date: _____ / _____ / _____

BUSINESS INFORMATION

Coverage is contingent upon underwriting review and approval of the following questionnaire.
Please note, if approved, the limit of coverage available for this optional coverage is: $250,000 with a $1,000,000 aggregate. We do not have any higher limits options available.

1. Does your organization currently have employees, volunteers or independent contractors? ❍ Yes ❍ No
   The term "Volunteers" means someone, including parent volunteers, who exerts control over or supervises participants.
2. Have any claims, allegations or charges of abuse, molestation or sexual misconduct been made against you or your organization or anyone working on behalf of your organization? ❍ Yes ❍ No
   If yes, please explain:_____
3. Are you aware of any occurrences that could lead to a claim? ❍ Yes ❍ No
   If yes please explain:_____
4. Do you, your organization or sanctioning/governing body have written procedures and training in place regarding the prevention and mitigation of abuse, molestation or sexual misconduct? ❍ Yes ❍ No

   If yes, do they include:

   - How to recognize the signs of abuse and molestation ❍ Yes ❍ No
   - All known, alleged or suspected abuse incidents must be reported to law enforcement ❍ Yes ❍ No
   - Procedures are provided or available to all paid and volunteer staff, and sanctioning/governing body members ❍ Yes ❍ No
   - No one-on-one situations allowed without visibility by others ❍ Yes ❍ No
   - A supervision plan to monitor all participants at the facility/event site that also prevents access to secluded areas such as closets, unsupervised rooms, etc. ❍ Yes ❍ No
   - A policy regarding appropriate and inappropriate physical contact, verbal interaction and electronic communications with children during and outside of regularly scheduled business activities ❍ Yes ❍ No

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CA # 0H64806, TX # 1554208, FL # L074590

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BUSINESS INFORMATION CONTINUED

5. Please complete the following questions regarding employee, volunteer, or independent contractor screening controls used by your organization.

Please Complete All Questions The term "Volunteers/Independent contractors" in the following questions means someone who exerts control over or supervises participants.	**Employees**	**Volunteers/Independent contractors**
Do you have employees and/or Volunteers/Independent contractors?	❍ Yes ❍ No	❍ Yes ❍ No
Are employee/volunteer/independent contractor applications required?	❍ Yes ❍ No	❍ Yes ❍ No
If yes, does the application include questions about whether the individual has ever been convicted for any crime involving physical violence or sex related offenses?	❍ Yes ❍ No	❍ Yes ❍ No
If yes, and applicant checks yes, do you reject the applicant?	❍ Yes ❍ No	❍ Yes ❍ No
Are background checks provided by a third party vendor/service?	❍ Yes ❍ No	❍ Yes ❍ No
If yes, do you reject an applicant with any history of physical violence or sex related offenses?	❍ Yes ❍ No	❍ Yes ❍ No

Please explain any "No" responses to questions asked in #5:_____

MAILING INFO

Submit completed questionnaire to us. Upon receipt we will review and, if accepted, will provide you with a quotation. Premium payment is needed in order to bind coverage.

- E-mail recsportsandmore@recsportsandmore.ahpcare.com
- Fax 1-913-754-5617
- Mail Academic HealthPlans, Inc.
  PO Box 81315
  Cleveland, OH 44181

REPRESENTATION STATEMENT

The undersigned authorized officer of the applicant declares that the statements set forth herein are true to the best of his or her knowledge. The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such changes, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing of this application does not bind the applicant to the insurer to complete the insurance.

I am aware that accurate reporting is required for premium calculation and that my books and records, as they relate to this coverage, may be examined or audited by the company at any time during the coverage period and up to three years thereafter. I acknowledge that intentional misrepresentation or misreporting may jeopardize coverage and that the company reserves the right to decline/void any ineligible coverage.

I further acknowledge that, I have reviewed all information provided with this enrollment form and understand the exclusions which apply, as well as the activities and operations for which coverage is not provided.

WHERE ALLOWED BY JURISDICTION, COSTS ARE 100% NON-REFUNDABLE/NON-TRANSFERRABLE ONCE COVERAGE BEGINS.

Applicant business name (from page 1): _____

Applicant or agent signature: _____ **Date:** _____

Printed name: _____ **Title:** _____

If an agent: Check here to acknowledge you are signing on behalf of the named insured ❍