



STATES SELF-INSURERS RISK RETENTION GROUP, INC.

PRIMARY APPLICATION FOR EXCESS LIABILITY INSURANCE

NOTICE:

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

NOTICE:

This application for insurance represents an affirmative warranty of the information provided by the applicant and will be utilized in the development of premium for any insurance to be issued to the applicant. Furthermore, this application will attach to and become part of any public entity liability insurance policy issued to the applicant. Failure to provide complete and accurate responses to all questions contained in this application may represent a basis for discontinuation and/or denial of coverage and/or revocation of the policy.

GENERAL INFORMATION

Please answer ALL questions, entering "none" or "not applicable" (N/A), where appropriate.

PLEASE PRINT OR TYPE ALL RESPONSES

1. Date of Application: _____
2. Desired Effective Date of Coverage: _____
3. Full Name of Applicant Entity (*First Named Insured AS IT WOULD BE SHOWN ON THE POLICY*):

4. *Other Named Insureds* (Other legal public entities created and/or contracted by the *First Named Insured* which are also to be shown as Named Insureds on the policy. Attach this information as a separate exhibit if necessary and identify exhibit number here.): _____
5. Mailing Address of Applicant Entity:

Address

City / State / Zip Code
6. Name of *Risk Manager* for Applicant Entity: _____
7. Name of *Insurance Buyer* for Applicant Entity (If different from Risk Manager): _____
8. Nature of Applicant Entity:
☐City ☐County ☐State ☐Authority (Describe): _____ ☐Other (Describe): _____



9. Population (please provide date of census on which population is based):

Population: _____ Census Year: _____

10. Provide *Total Operating Expenditures*:

☐ **I HAVE ATTACHED THE MOST RECENT ANNUAL COMPREHENSIVE AUDITED FINANCIAL REPORT (C.A.F.R.)**

11. Please provide your *Coverage History Information* for the last two (2) years:

PRIMARY LEVEL COVERAGE:

	POLICY YEAR: _____				POLICY YEAR: _____			
	GENERAL LIABILITY	PUBLIC OFFICIALS LIABILITY	LAW ENFORCEMENT LIABILITY	AUTOMOBILE LIABILITY	GENERAL LIABILITY	PUBLIC OFFICIALS LIABILITY	LAW ENFORCEMENT LIABILITY	AUTOMOBILE LIABILITY
INSURANCE COMPANY NAME (If Self-Insured, mark as "S-I"):	_____	_____	_____	_____	_____	_____	_____	_____
LIMITS OR SELF-INSURED RETENTION:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
PREMIUM:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

EXCESS LEVEL COVERAGE:

	POLICY YEAR: _____				POLICY YEAR: _____			
	GENERAL LIABILITY	PUBLIC OFFICIALS LIABILITY	LAW ENFORCEMENT LIABILITY	AUTOMOBILE LIABILITY	GENERAL LIABILITY	PUBLIC OFFICIALS LIABILITY	LAW ENFORCEMENT LIABILITY	AUTOMOBILE LIABILITY
INSURANCE COMPANY NAME:	_____	_____	_____	_____	_____	_____	_____	_____
LIMITS:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
PREMIUM:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

12. Has any company declined, canceled or non-renewed any of the liability lines listed above in the **last five (5) years**? ☐ YES ☐ NO

If YES, please explain: _____



13. a. For the coverage lines listed below, please indicate whether your current coverage is **claims-made**.

General Liability: ☐ YES: RETROACTIVE DATE: _____ ☐ NO

Public Officials Liability: ☐ YES: RETROACTIVE DATE: _____ ☐ NO

Law Enforcement Liability: ☐ YES: RETROACTIVE DATE: _____ ☐ NO

Automobile Liability: ☐ YES: RETROACTIVE DATE: _____ ☐ NO

Other Liability (specify): _____ ☐ YES: RETROACTIVE DATE: _____ ☐ NO

- b. States offers either "Occurrence" or "Claims-made" coverage forms. Please indicate which coverage form you are requesting:

☐ "OCCURRENCE" POLICY FORM

☐ "CLAIMS-MADE" POLICY FORM

If Claims made, please indicate the retroactive date requested: _____

14. Indicate the Self-Insured Retention (SIR), or attachment point if commercial primary coverage is carried -- and the limits requested. SIRs of \$250,000 or greater are available. SIR level/attachment point and limits level are subject to States underwriting review and approval.

States Excess Coverage:

SIR (or Attachment Point) \$ _____ Limits Desired: \$ _____

PLEASE NOTE: States Self-Insurers Risk Retention Group, Inc. is a member-owned company. States requires that each of its participants have effective claim management and loss control programs in place and functioning. Company representatives may visit your entity to review with you your claim management and loss control programs. Participants in the States program are expected to proactively address deficient areas that may be noted in these reviews.

15. CLAIM MANAGEMENT OVERVIEW:

- a. Please indicate how you currently handle claims within your self-insured retention or insured primary layer:

1) Internal Staff: ☐ YES ☐ NO

2) Independent Contractor or Third Party Administrator: ☐ YES ☐ NO

If yes, please describe who service provider is: _____

3) Insurance Company: ☐ YES ☐ NO

4) Combination of above: ☐ YES ☐ NO

If yes, please describe arrangement: _____

- b. Please list the names, contact phone numbers, years of experience and claim paying authority level for claim handling personnel:

NAME	CONTACT PHONE #	EXPERIENCE (# of Years)	AUTHORITY LEVEL
			\$
			\$
			\$



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- c. Who is responsible for reporting potential claims to your excess liability insurance carrier?

Name: _____ Title: _____

Contact Phone No. _____

- d. Are claim loss and expense reserves established for each claim? ☐ YES ☐ NO

If **YES**, what reserve setting basis or methodology is used? _____

If **NO**, please explain how claim valuations are arrived at: _____

- e. Do you use an automated Risk Management Information System? ☐ YES ☐ NO

If **YES**, please describe: _____

- f. Please indicate whether your current "Claim Summary Report" format includes the following:

☐ Claim Description ☐ Paid Amount ☐ Reserve Amount ☐ Current Status of Claim

- g. Please indicate the type of resource used to handle your claim *litigation*:

☐ Internal Legal Staff: _____%
AMOUNT USED

☐ External, Independent Legal Counsel: _____%
AMOUNT USED

If external, independent Legal Counsel is used, please describe the criteria used to determine assignment of cases and procedures for litigation cost control: _____

- h. Please indicate how your claim files and reports are maintained (check all that apply):

☐ Internal File System

☐ External File System Maintained by Service Provider

☐ Centralized Location

☐ Coordinated by one individual: Name: _____ Phone No. _____



16. LOSS CONTROL PROGRAM OVERVIEW:

- a. Please indicate how you currently coordinate loss control efforts within your public entity:
- 1) Internal Staff: ☐ YES ☐ NO
 - 2) Independent Contractor or Third Party Administrator: ☐ YES ☐ NO
If **YES**, please describe who service provider is: _____
 - 3) Insurance Company: ☐ YES ☐ NO
 - 4) Combination of above: ☐ YES ☐ NO
If **YES**, please describe arrangement: _____
- b. Who should be contacted in order to schedule a review of liability loss control programming in your public entity, and to discuss ongoing loss control matters?
Name: _____ Phone No. _____
- c. Please indicate which of the following components help make up your current, day-to-day liability loss control management (check all that apply):
- ☐ Internal Manager of Loss Control Programs
 - ☐ Loss Control Review Committee
 - ☐ External Resources -- Describe: _____
- d. Has your public entity governing body adopted a formal, written liability loss control policy?
☐ YES ☐ NO
- e. For the following items, please indicate whether your public entity has existing loss control programs and loss control policies in place to address *third party liability exposures* (check all that apply):
- ☐ General Liability
 - ☐ Public Officials Liability
 - ☐ Law Enforcement Liability (including jails and detention facilities)
 - ☐ Automobile Liability/Vehicle and Fleet Safety
 - ☐ Contractual Liability
 - ☐ Employment Practices/Personnel Procedures
 - ☐ Parks and Recreation Operations
 - ☐ Special Events/Celebrations/Festivals
 - ☐ Street and Road Maintenance
 - ☐ Public Works Operations (including utility infrastructure maintenance)
 - ☐ Bridge Inspection and Maintenance
 - ☐ Landfill Operations
 - ☐ Social Services Operations
 - ☐ Delivery of Health Care Services
 - ☐ Land Use/Zoning/Development Practices
 - ☐ Fire Service Operations
 - ☐ Abatement of Asbestos
 - ☐ Abatement of Lead



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- f. Where formal and/or written third party liability loss control programs are not in place, please describe the policies and procedures followed to address and administer loss control efforts: _____



- g. Are loss costs and related expenses allocated back to your public entity's departments?
☐YES ☐NO
- h. Does your public entity incorporate ratings dealing with the effectiveness of loss control programs into the performance reviews of its administrators, department heads, managers and supervisors?
☐YES ☐NO
- i. Does your public entity conduct periodic liability hazard recognition and control inspections of all of its premises and operations? ☐YES ☐NO
If **YES**, how often are these inspections done? _____
Please describe how these inspections are documented: _____

If **NO**, please describe your public entity's current methods for identifying, controlling and eliminating liability hazards: _____
- j. Does your public entity have a structured system in place to periodically analyze the effectiveness of loss control efforts and to make corresponding changes in loss control programming?
☐YES ☐NO
- k. Does your public entity have an internal loss cost analysis system that can be used to prompt loss control program changes as needed? ☐YES ☐NO



17. OPERATIONS AND EXPOSURE INFORMATION

PLEASE PROVIDE INFORMATION ON ALL OF THE APPLICANT PUBLIC ENTITY'S OPERATIONAL EXPOSURES AS REQUESTED BELOW. NOTE THAT COVERAGE MAY NOT BE AVAILABLE FOR ALL OPERATIONS OR EXPOSURES. PLEASE READ THE POLICY CAREFULLY. ATTACH NUMBERED EXHIBITS FOR OPERATIONAL EXPOSURES WHERE YOU WISH TO SHOW ADDITIONAL INFORMATION.

OPERATION/EXPOSURE DESCRIPTION	DOES THIS EXPOSURE EXIST IN YOUR PUBLIC ENTITY?		IF YES, IS EXPOSURE OPERATED BY YOUR PUBLIC ENTITY OR CONTRACTED OUT?		EXPOSURE INFORMATION
	YES	NO	OPERATED	CONTRACTED	
AIRPORTS /AIRCRAFT (NOTE: AIRPORTS AND AIRCRAFT OPERATIONS COVERAGE IS EXCLUDED -- INFORMATION AT RIGHT IS NEEDED TO APPLY APPROPRIATE RATING CREDITS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF AIRPORTS: _____ NO. OF AIRCRAFT: _____ TOTAL ANNUAL EXPENDITURES: \$ _____
AMUSEMENT PARKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TOTAL ANNUAL RECEIPTS: \$ _____ TOTAL ANNUAL EXPENDITURES: \$ _____
AQUATICS FACILITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF POOLS: _____ NO. OF BEACHES: _____ NO. OF WATERSLIDES: _____ NO. OF WAVE POOLS: _____ NO. OF DIVING APPARATUS . . . _____ NO. OF 1 METER UNITS: _____ NO. OF 3 METER UNITS: _____ NO. OVER 3 METERS: _____
ARENAS / AUDITORIUMS / CONVENTION CENTERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF EACH TYPE: _____ TOTAL AREA OF EACH: _____ SQ. FT. OCCUPANCY CAPACITY OF EACH: _____
BOATS / WATERCRAFT (OVER 50 HP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF CRAFT: _____ FOR EACH BOAT / WATERCRAFT OVER 50 HP: a) LENGTH: _____ b) TYPE OF USE: _____
BRIDGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OVER 20' IN LENGTH: _____ FOR EACH BRIDGE: _____ a) HOW OFTEN INSPECTED? _____ b) ATTACH ANY PENDING RECOMMENDATIONS FROM INSPECTIONS.
DAY CARE AND/OR NURSERY UNDERWRITING OF THIS EXPOSURE REQUIRES THE COMPLETION OF SUPPLEMENTAL INFORMATION SPECIFIC TO THIS EXPOSURE.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COMPLETE STATES' SUPPLEMENTAL APPLICATION INFORMATION FOR DAY CARE AND/OR NURSERY.
FAIRGROUNDS / CARNIVALS / FESTIVALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AREA OCCUPIED: _____ ACRES DESCRIBE NATURE OF EACH IN DETAIL ON EXHIBIT AND ATTACH TO APPLICATION.



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	YES	NO	OPERATED	CONTRACTED	
FIREFIGHTING AND EMERGENCY MEDICAL SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF FULL-TIME FIREFIGHTERS: _____ NO. OF PART-TIME FIREFIGHTERS: _____ NO. OF VOLUNTEER FIREFIGHTERS: _____ NO. OF EMT's / PARAMEDICS: _____ NO. OF PHYSICIAN'S ASSISTANTS: _____
FIREWORKS DISPLAYS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. CONDUCTED IN EACH CALENDAR YEAR: _____ DO TRAINED AND CERTIFIED PERSONNEL CONDUCT DISPLAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF CONTRACTED, IS EVIDENCE OF LIABILITY INSURANCE OBTAINED AND REVIEWED? <input type="checkbox"/> YES <input type="checkbox"/> NO
GOLF COURSES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF COURSES: _____ TOTAL ANNUAL RECEIPTS: \$ _____ TOTAL ANNUAL EXPENDITURES: \$ _____
GRANDSTANDS / STADIUMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF FACILITIES <i>WITH SEATING CAPACITY OF 5,000 OR MORE</i> : _____ SEATING CAPACITY OF EACH FACILITY <i>WITH A SEATING CAPACITY OF 5,000 OR MORE</i> : _____ TOTAL ANNUAL EXPENDITURES <i>FOR ALL GRANDSTAND / STADIUM FACILITIES (Regardless of Size)</i> : \$ _____
HEALTH CLINICS / HOSPITALS (NOTE: MEDICAL MALPRACTICE COVERAGE IS EXCLUDED)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF CLINIC FACILITIES: _____ NO. OF HOSPITAL FACILITIES: _____ NO. OF BEDS FOR EACH FACILITY: _____ AREA OF EACH FACILITY: _____ SQ. FT. TOTAL ANNUAL EXPENDITURES: \$ _____
HOUSING, REDEVELOPMENT & ECONOMIC DEVELOPMENT AUTHORITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF HOUSING AUTHORITIES: _____ NO. OF UNITS: _____ NO. OF REDEVELOPMENT AUTHORITIES: _____ NO. OF ACRES: _____ NO. OF ECONOMIC DEVELOPMENT AUTHORITIES: _____ NO. OF ACRES: _____
HUMAN RESOURCES / PERSONNEL UNDERWRITING OF THIS EXPOSURE REQUIRES THE COMPLETION OF SUPPLEMENTAL INFORMATION SPECIFIC TO THIS EXPOSURE.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SEE PAGE 13 OF THIS APPLICATION FOR THE PUBLIC OFFICIALS LIABILITY SUPPLEMENTAL INFORMATION SECTION.
INDEPENDENT CONTRACTORS / CONSTRUCTION OPERATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TOTAL ANNUAL EXPENDITURES: \$ _____



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	YES	NO	OPERATED	CONTRACTED	
JAILS / DETENTION FACILITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF JAIL FACILITIES: _____ NO. OF ADULT DETENTION FACILITIES: _____ NO. OF JUVENILE DETENTION FACILITIES: _____ FOR <u>EACH</u> FACILITY PLEASE PROVIDE THE FOLLOWING INFORMATION: a) AREA: _____ SQ. FT. b) ANNUAL EXPENDITURES: \$ _____ c) AVERAGE DAILY NO. OF INMATES: _____ d) STATE CERTIFIED CAPACITY: _____ e) YEAR BUILT: _____ f) IS BUILDING SPRINKLERED? <input type="checkbox"/> YES <input type="checkbox"/> NO g) IS THE FACILITY ACCREDITED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, BY WHOM? _____ h) PLEASE PROVIDE DETAILED INFORMATION CONCERNING ANY SUICIDES THAT HAVE OCCURRED IN THE FACILITY WITHIN THE LAST 3 YEARS. (ATTACH SEPARATE EXHIBIT)
LANDFILLS / DUMPS (NOTE: POLLUTION COVERAGE IS ABSOLUTELY EXCLUDED IN STATES' EXCESS LIABILITY POLICY.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF OPEN SITES: _____ NO. OF CLOSED SITES: _____ ARE ANY SITES DEEMED HAZARDOUS WASTE SITES? <input type="checkbox"/> YES <input type="checkbox"/> NO IS ANY LEGAL ACTION OR LITIGATION PENDING THAT INVOLVES ANY SITES? <input type="checkbox"/> YES <input type="checkbox"/> NO ARE ANY SITES DEEMED FEDERAL OR STATE "SUPERFUND" SITES? <input type="checkbox"/> YES <input type="checkbox"/> NO
LAND USE / ZONING & PLANNING UNDERWRITING OF THIS EXPOSURE REQUIRES THE COMPLETION OF SUPPLEMENTAL INFORMATION SPECIFIC TO THIS EXPOSURE.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SEE PAGE 13 OF THIS APPLICATION FOR THE PUBLIC OFFICIALS LIABILITY SUPPLEMENTAL INFORMATION SECTION.
LAW ENFORCEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF SWORN PERSONNEL . . . a) FULL TIME: _____ b) PART TIME: _____ NO. OF VOLUNTEER / AUXILIARY: _____ TOTAL ANNUAL EXPENDITURES: \$ _____ DOES THE AGENCY HAVE A COMPLETE POLICY & PROCEDURES MANUAL? <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN WAS THE POLICY & PROCEDURES MANUAL LAST FULLY REVISED? _____ IS THE MANUAL DISTRIBUTED TO ALL PERSONNEL? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW OFTEN IS THE MANUAL REVIEWED WITH PERSONNEL? _____ DOES THE AGENCY HAVE A CANINE UNIT? <input type="checkbox"/> YES <input type="checkbox"/> NO IS THE AGENCY ACCREDITED? <input type="checkbox"/> YES <input type="checkbox"/> NO



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	YES	NO	OPERATED	CONTRACTED	
LIQUOR / ALCOHOL SALES (Including sales at special events, sporting events, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ANNUAL RECEIPTS: \$_____
NURSING HOMES & RELATED FACILITIES (NOTE: MEDICAL MALPRACTICE COVERAGE IS EXCLUDED) ATTACH A COPY OF YOUR CURRENT OPERATING CERTIFICATE / LICENSE FOR EACH FACILITY. INCLUDE ANY INFORMATION CONCERNING ANY PROVISIONAL OPERATIONS LICENSING THAT IS IN EFFECT.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LIST NO. OF FACILITIES BY TYPE WITH SUPPORTING INFORMATION REQUESTED . . . NO. OF SKILLED NURSING FACILITIES: _____ a) AREA: _____ SQ. FT. b) NO. OF BEDS: _____ c) ANNUAL EXPENDITURES: \$_____ NO. OF ASSISTED LIVING FACILITIES: _____ a) AREA: _____ SQ. FT. b) NO. OF BEDS: _____ c) ANNUAL EXPENDITURES: \$_____ NO. OF OTHER FACILITIES (DESCRIBE): _____ a) AREA: _____ SQ. FT. b) NO. OF BEDS: _____ c) ANNUAL EXPENDITURES: \$_____
PARKS & RECREATION (NOT INCLUDING AQUATICS FACILITIES)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NO. OF PARKS: _____ NO. OF RECREATION BUILDINGS: _____ PLEASE MARK EACH RECREATIONAL FEATURE THAT EXISTS IN YOUR ENTITY'S OPERATIONS: <input type="checkbox"/> DAY CAMPS (If checked, complete supplemental application information.) <input type="checkbox"/> SKATEBOARD PARKS <input type="checkbox"/> INLINE SKATING PARKS <input type="checkbox"/> BICYCLE MOTOCROSS (BMX) COURSES <input type="checkbox"/> MOTORIZED VEHICLE COURSES / TRACKS <input type="checkbox"/> ZOOS <input type="checkbox"/> TRAMPOLINES <input type="checkbox"/> SADDLE ANIMAL RENTAL <input type="checkbox"/> BLEACHER SEATING (INTERIOR OR EXTERIOR) IS BLEACHER SEATING IN COMPLIANCE WITH CURRENT SAFETY STANDARDS & BUILDING CODES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PLAYGROUND EQUIPMENT IS PLAY EQUIPMENT IN COMPLIANCE WITH CURRENT CONSUMER PRODUCT SAFETY COMMISSION GUIDELINES AND A.S.T.M. STANDARDS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SKI FACILITIES (ATTACH DESCRIPTION) ARE ALL PARKS AND RECREATION FACILITIES UNDER A REGULAR INSPECTION AND MAINTENANCE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO



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PUBLIC OFFICIALS ACTIONS UNDERWRITING OF THIS EXPOSURE REQUIRES THE COMPLETION OF SUPPLEMENTAL INFORMATION SPECIFIC TO THIS EXPOSURE.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	OPERATED <input type="checkbox"/>	CONTRACTED <input type="checkbox"/>	SEE PAGE 13 OF THIS APPLICATION FOR THE PUBLIC OFFICIALS LIABILITY SUPPLEMENTAL INFORMATION SECTION.
PUBLIC SCHOOLS UNDERWRITING OF THIS EXPOSURE REQUIRES THE COMPLETION OF AN APPLICATION SPECIFIC TO THIS OPERATION.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	OPERATED <input type="checkbox"/>	CONTRACTED <input type="checkbox"/>	SEE <u>SEPARATE APPLICATION FORM</u> FOR PUBLIC SCHOOLS.
STREETS & ROADS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	OPERATED <input type="checkbox"/>	CONTRACTED <input type="checkbox"/>	TOTAL MILES: _____ MILES ANNUAL EXPENDITURES: \$ _____
TRANSPORTATION SYSTEMS & SERVICES (Not Associated with Schools)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	OPERATED <input type="checkbox"/>	CONTRACTED <input type="checkbox"/> IF CONTRACTED, SEE NEXT COLUMN FOR ADDITIONAL INFORMATION NEEDED.	ANNUAL EXPENDITURES: \$ _____ TRANSIT SYSTEM OPERATIONS INFORMATION SHOULD BE ATTACHED ON A SEPARATE EXHIBIT. PLEASE INCLUDE DETAILS CONCERNING THE TYPE OF OPERATION (i.e., BUS, LIGHT RAIL), SIZE OF THE SYSTEM AND DETAILS OF THE LIABILITY LOSS CONTROL PROGRAM FOR THE SYSTEM. IF TRANSPORTATION IS CONTRACTED, PLEASE PROVIDE THE FOLLOWING ADDITIONAL INFORMATION: <input type="checkbox"/> CERTIFICATE(S) OF INSURANCE FROM THE CONTRACTOR EVIDENCING YOUR PUBLIC ENTITY AS AN ADDITIONAL NAMED INSURED ON THE CONTRACTOR'S AUTOMOBILE LIABILITY & GENERAL LIABILITY COVERAGE. <input type="checkbox"/> THE LIMITS OF LIABILITY REQUIRED OF THE CONTRACTOR FOR AUTO LIABILITY & GENERAL LIABILITY COVERAGE. <input type="checkbox"/> THE DRIVER QUALIFICATION STANDARDS YOU REQUIRE THE CONTRACTOR TO FOLLOW. <input type="checkbox"/> AN OUTLINE OF THE POLICIES & PROCEDURES YOU FOLLOW FOR REVIEWING THE ONGOING ACCEPTABILITY OF THE CONTRACTOR, THEIR DRIVERS, MAINTENANCE PRACTICES, FLEET SAFETY PROGRAMS & OTHER PERTINENT LOSS CONTROL PRACTICES.



OPERATION/EXPOSURE DESCRIPTION	DOES THIS EXPOSURE EXIST IN YOUR PUBLIC ENTITY?		IF YES, IS EXPOSURE OPERATED BY YOUR PUBLIC ENTITY OR CONTRACTED OUT?		EXPOSURE INFORMATION
	YES	NO	OPERATED	CONTRACTED	
UTILITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>PLEASE MARK THE UTILITIES THAT YOUR ENTITY OPERATES:</p> <p><input type="checkbox"/> POTABLE (DRINKING) WATER a) ANNUAL PAYROLL: \$ _____ b) ANNUAL DISTRIBUTION: _____ GALLONS</p> <p><input type="checkbox"/> SANITARY SEWER a) ANNUAL PAYROLL: \$ _____ b) NO. OF MILES OF LINES: _____ MILES</p> <p><input type="checkbox"/> ELECTRICAL a) ANNUAL PAYROLL: \$ _____ b) ANNUAL DISTRIBUTION: _____ MWH</p> <p><input type="checkbox"/> NATURAL GAS a) ANNUAL PAYROLL: \$ _____ b) ANNUAL DISTRIBUTION: _____ C.C.F.</p> <p><input type="checkbox"/> STEAM a) ANNUAL PAYROLL: \$ _____ b) ANNUAL DISTRIBUTION: _____ C.C.F.</p> <p><input type="checkbox"/> OTHER (DESCRIBE): _____</p> <p>UTILITY OPERATIONS MAY REQUIRE THE COMPLETION OF ADDITIONAL UNDERWRITING INFORMATION.</p>
WELFARE BENEFITS ADMINISTRATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>ANNUAL BENEFITS PAID: \$ _____ (DO NOT INCLUDE ADMINISTRATIVE COSTS)</p>
WATERFRONT FACILITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>PLEASE MARK EACH WATERFRONT FEATURE THAT EXISTS IN YOUR ENTITY'S OPERATIONS:</p> <p><input type="checkbox"/> DOCKS NO. OF DOCKS: _____ ELECTRICAL SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO FUEL SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO DIMENSIONS: _____ LINEAR FT.</p> <p><input type="checkbox"/> MARINAS NO. OF MARINAS: _____ ELECTRICAL SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO FUEL SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO TOTAL BOAT CAPACITY: _____</p> <p><input type="checkbox"/> PIERS / WHARVES NO. OF PIERS / WHARVES: _____ ELECTRICAL SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO FUEL SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO ACCESSIBLE BY CHARTER AND COMMERCIAL VESSELS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PLEASE INCLUDE A SEPARATE EXHIBIT DETAILING THE USAGE OF ANY WATERFRONT FACILITIES.</p>



18. AUTOMOBILE LIABILITY INFORMATION

FOR EACH VEHICLE TYPE LISTED BELOW, PLEASE PROVIDE THE TOTAL NUMBER OF OWNED OR LEASED VEHICLES IN YOUR ENTITY'S OPERATIONS. DO NOT INCLUDE VEHICLES OWNED OR LEASED BY SCHOOLS. THAT INFORMATION IS PROVIDED IN A SEPARATE SCHOOLS APPLICATION.

VEHICLE TYPE:	TOTAL NO.
PRIVATE PASSENGER -- <u>NON-LAW ENFORCEMENT USE:</u> _____	_____
PRIVATE PASSENGER -- <u>LAW ENFORCEMENT USE</u> _____	_____
PATROL VEHICLES: _____	_____
NON-PATROL VEHICLES (DESCRIBE): _____	_____
LIGHT TRUCKS: UNDER 10,000 LBS. GVW - INCLUDING CARGO VANS _____	_____
MEDIUM TRUCKS: 10,000 TO 26,000 LBS. GVW _____	_____
HEAVY TRUCKS: OVER 26,000 LBS. GVW _____	_____
AMBULANCES / EMERGENCY MEDICAL / RESCUE: _____	_____
FIRE-FIGHTING APPARATUS: _____	_____
MOTORCYCLES: _____	_____
DESCRIBE USE: _____	_____
BUSES: CAPACITY OF 25 OR LESS:	_____
BUSES: CAPACITY GREATER THAN 25:	_____
PASSENGER VANS:	_____
11 OR LESS PASSENGERS CAP.: _____	_____
12-15 PASSENGERS* CAP.: _____	_____
DESCRIBE USE: _____	_____
*15 Passenger Van operations require the completion of supplemental application information.	_____
OTHER VEHICLES (DESCRIBE): _____	_____

SUPPLEMENTAL INFORMATION FOR PUBLIC OFFICIALS LIABILITY

Please answer ALL questions, entering "none" or "not applicable" (N/A), where appropriate.

19. CONTACT INFORMATION:

General Administration Contact:	_____	_____
	NAME	PHONE NO.
Loss Control Contact --		
Employment Practices:	_____	_____
	NAME	PHONE NO.
Loss Control Contact --		
Land Use and Zoning Practices:	_____	_____
	NAME	PHONE NO.



20. MANAGEMENT STRUCTURE:

POSITION	NO. OF YEARS IN OFFICE	TERM OF OFFICE
Senior <u>Elected</u> Position _____ (Position Name)	_____	_____
Senior <u>Appointed</u> Position: _____ (Position Name)	_____	_____
Type of <i>Governing Body</i> : _____ (Description)		

21. Please indicate if any of the following have occurred within the last five (5) years:

- a. Any Grand Jury indictments of any public officials? ☐ YES ☐ NO
- b. Any assault and battery charges made against the entity or its officials? ☐ YES ☐ NO
- c. Any riot or civil commotion incidents? ☐ YES ☐ NO

If **YES** for *any* of the items listed above, please provide a description of the situation (or attach exhibits providing this information): _____

22. Does the Applicant Entity provide or arrange for training for new and less-experienced public officials in the legislative process and in appropriate governing procedures? ☐ YES ☐ NO

If **YES**, please describe the training resources used: _____

PLEASE PROVIDE INFORMATION ON ALL OF THE APPLICANT PUBLIC ENTITY'S PUBLIC OFFICIALS EXPOSURES AS REQUESTED BELOW. NOTE THAT COVERAGE MAY NOT BE AVAILABLE FOR ALL OPERATIONS OR EXPOSURES: PLEASE READ THE POLICY CAREFULLY. ATTACH NUMBERED EXHIBITS FOR OPERATIONAL EXPOSURES WHERE YOU WISH TO SHOW ADDITIONAL INFORMATION.

23. EMPLOYMENT PRACTICES INFORMATION . . .

- a. Does the Applicant Entity have a central Human Resources / Personnel Department that oversees employment practices for all functions of the entity? ☐ YES ☐ NO

- b. Please indicate whether the following policies and procedures exist in written form and are implemented:

- 1) Hiring process? ☐ YES ☐ NO
- 2) Employee disciplinary process? ☐ YES ☐ NO
- 3) Termination process? ☐ YES ☐ NO
- 4) Sexual harassment prevention policy? ☐ YES ☐ NO
- 5) Equal Employment Opportunity policy? ☐ YES ☐ NO
- 6) Americans with Disabilities Act compliance policy? ☐ YES ☐ NO
- 7) Fair Labor Standards Act compliance policy? ☐ YES ☐ NO

- c. Does the Applicant Entity have an employment practices training program in place for new supervisors? ☐ YES ☐ NO

- d. Does the Applicant Entity use legal counsel resources experienced in employment matters? ☐ YES ☐ NO



24. LAND USE / PLANNING / ZONING PRACTICES INFORMATION . . .

- a. Does the Applicant Entity have an up-to-date Comprehensive Plan to help guide its decision-making regarding land use? ☐YES ☐NO

If **YES**, when was the Comprehensive Plan last updated? _____
DATE

- b. Does the Applicant Entity use legal counsel resources experienced in land use matters? ☐YES ☐NO

- c. Has the Applicant Entity adjusted any zoning designations downward within the last three (3) years? ☐YES ☐NO

If **YES**, please describe circumstances: _____

- d. Please indicate below the percentage of each zone designation that exists in the Applicant Entity:

Agricultural: _____% Residential: _____% Commercial: _____%

Industrial: _____% Other (Describe): _____%

- e. Does the Applicant Entity have a formal, documented process for handling property condemnation proceedings? ☐YES ☐NO

If **YES**, please describe the process: _____

- f. Does the Applicant Entity anticipate the annexation of any property within the next three (3) years? ☐YES ☐NO

If **YES**, please describe circumstances: _____

25. PUBLIC INSPECTION ACTIVITY . . .

- a. Please check the following areas for which the Applicant Entity conducts compliance inspections:

☐Building Code Enforcement

☐Fire Safety Code Enforcement

☐Food Service Operations

☐Public Health

☐Healthcare Facilities

☐Other (Describe): _____

- b. Are applicable certifications, credentialing and training provided to those who are responsible for conducting inspections? ☐YES ☐NO



26. LOSS HISTORY INFORMATION

PLEASE PROVIDE A SCHEDULE OF *TOTAL INCURRED LOSSES* (INCLUDING PAID AND RESERVED) FOR ALL LIABILITY LOSSES DURING THE *CURRENT FISCAL YEAR* AND THE IMMEDIATELY PRECEDING *FIVE (5) FISCAL YEARS*. PROVIDE SPECIFIC LOSS DETAILS ON ANY LOSSES THAT INVOLVED THE FOLLOWING:

- ANY LOSSES THAT HAVE EXCEEDED \$25,000 IN TOTAL INCURRED LOSS (FROM "GROUND-UP")
- ANY LOSSES INVOLVING DEATH, TOTAL PERMANENT DISABILITY, BRAIN DAMAGE, SPINAL CORD DAMAGE, PARAPLEGIA, QUADRIPLÉGIA, LOSS OF ONE OR MORE LIMBS, THIRD DEGREE BURNS INVOLVING MORE THAN 25% OF THE INJURED PARTY'S BODY, OR ANY OTHER BODILY INJURY WHICH HAS THE POTENTIAL TO DEVELOP INTO A SERIOUS CLAIM.

SUPPLEMENTARY FORMS ARE PROVIDED WITH THIS APPLICATION TO PROVIDE A PLACE FOR YOU TO RECORD THE REQUESTED LOSS INFORMATION. YOU CAN SUBSTITUTE YOUR OWN "LOSS SUMMARY REPORT" FOR THIS INFORMATION AS LONG AS THE INFORMATION REQUESTED IS PROVIDED. THANK YOU!

AFFIRMATION OF APPLICATION DATA

27. Do you know of any facts or circumstances which could give rise to any payment under States' policy that has not already been disclosed in this Application and its Supplements or otherwise brought to the attention of States Self-Insurers Risk Retention Group, Inc.? ☐ YES ☐ NO

If **YES**, please explain: _____

28. Acting with the authority of and on behalf of the applicant public entity, I hereby confirm that all information provided to the States Self-Insurers Risk Retention Group, Inc. on and in conjunction with this Application and its Supplements is true and correct and no material information has been withheld.

SIGNATURE

PRINT NAME

DATE

TITLE

(_____)_____
PHONE NO.

(_____)_____
FAX NO.

E-MAIL ADDRESS



States Self-Insurers Risk Retention Group, Inc.
Primary Application for Excess Liability Insurance

COMMUNICATION POLICY

States Self-Insurers Risk Retention Group, Inc. - as the Company's name implies, is a risk retention group. As such, and pursuant to the Federal Liability Risk Retention Act of 1986, States' insureds are also the owners of the Company through States Self-Insurers Trust.

The nature of this relationship requires - and the Company is fostered by - an on-going, open and direct communication channel between States and its owner-insureds. Such communications enhance the recognition of ownership which has been cited as an issue of extreme importance by the United States Government Accountability Office (GAO).

Prospective owner-insureds of States accessing the risk retention group through representation by an agent, broker, or consultant include and involve such representative in their potential relationship with States. **States recognizes that members partner with agents, brokers, or consultants who are valuable resources in the insurance decision-making process, and it is not States' intent to interfere with this relationship.** States recognizes the agent, broker, or consultant that the prospective owner-insured of States chooses is a representative of the owner-insured, and not a representative of States Self-Insurers Risk Retention Group, Inc.

Because of the direct relationship States has with its insureds, communication with prospective members, either directly or through an agent, broker or consultant requires a representative of States be included in the process, and, where possible, at the final presentation of States program to the prospective member.

To ensure transparency in the insurance transaction, all proposals provided by States will be on a net basis. Fees related to the services rendered by an agent, broker or consultant are between the insured and their agent, broker or consultant. If the negotiated fee is to be collected as a commission and added to the net premium, States will need written authorization from the insured to do so. Such authorization shall include a designated percentage of the premium or a dollar amount to be collected.

I have read and understand this communication policy.

Signed: Representative for the Public Entity

Date

Signed: Representative for the Agent/Broker/Consultant

Date

THANK YOU FOR COMPLETING THIS APPLICATION. PLEASE SUBMIT THE APPLICATION TO:



**STATES SELF-INSURERS RISK RETENTION GROUP, INC.
UNDERWRITING DEPARTMENT
c/o BRAC, LLC
222 SOUTH NINTH STREET, SUITE 2700
MINNEAPOLIS, MN 55402-3332**

1-800-640-0345

(612) 766-3310

Fax: (612) 766-3399

www.statesrrg.com



STATES SELF-INSURERS RISK RETENTION GROUP, INC.

LOSS HISTORY INFORMATION ---- APPLICATION SUPPLEMENT #1

PLEASE PHOTOCOPY THIS FORM IF ADDITIONAL COPIES ARE NEEDED

ATTACHES TO THE APPLICATION FOR: _____

NAME OF APPLICANT PUBLIC ENTITY

DATED _____

1. Please indicate incurred losses from "ground up". Separate amounts by loss paid and total incurred.

		YEAR: _____	YEAR: _____	YEAR: _____	YEAR: _____	YEAR: _____
GENERAL LIABILITY:	PAID:	\$	\$	\$	\$	\$
	INCURRED:	\$	\$	\$	\$	\$
AUTOMOBILE LIABILITY:	PAID:	\$	\$	\$	\$	\$
	INCURRED:	\$	\$	\$	\$	\$
PUBLIC OFFICIALS LIABILITY:	PAID:	\$	\$	\$	\$	\$
	INCURRED:	\$	\$	\$	\$	\$
LAW ENFORCEMENT LIABILITY:	PAID:	\$	\$	\$	\$	\$
	INCURRED:	\$	\$	\$	\$	\$
OTHER (DESCRIBE):	PAID:	\$	\$	\$	\$	\$
	INCURRED:	\$	\$	\$	\$	\$
TOTAL PAID:		\$	\$	\$	\$	\$
TOTAL INCURRED:		\$	\$	\$	\$	\$

2. Valuation date for this information: _____

3. Are loss adjustment expenses, defense costs, etc., included in these amounts? ☐ YES ☐ NO

4. Please provide details on deductibles and self-insured retentions for each year.

5. PAGE _____ OF _____ PAGES



STATES SELF-INSURERS RISK RETENTION GROUP, INC.

LOSS HISTORY INFORMATION ---- APPLICATION SUPPLEMENT #2

PLEASE PHOTOCOPY THIS FORM IF ADDITIONAL COPIES ARE NEEDED

ATTACHES TO THE APPLICATION FOR: _____

NAME OF APPLICANT PUBLIC ENTITY

DATED _____

Please provide the requested details for each individual loss that the applicant has incurred during the current policy year and each of the immediately preceding five (5) full years for:

- ANY LOSSES THAT HAVE EXCEEDED \$25,000 IN TOTAL INCURRED LOSS (FROM "GROUND UP")
- ANY LOSSES INVOLVING DEATH, TOTAL PERMANENT DISABILITY, BRAIN DAMAGE, SPINAL CORD DAMAGE, PARAPLEGIA, QUADRIPLÉGIA, LOSS OF ONE OR MORE LIMBS, THIRD DEGREE BURNS INVOLVING MORE THAN 25% OF THE INJURED PARTY'S BODY, OR ANY OTHER BODILY INJURY WHICH HAS THE POTENTIAL TO DEVELOP INTO A SERIOUS CLAIM.

Please report ALL losses regardless of whether they are based on actual claims submitted to the applicant or relate to incidents of which the applicant is aware and which meet the above criteria or are expected to meet the above criteria.

Please Print or type All Responses

1. CLAIMANT'S NAME: _____
2. DATE OF LOSS: _____
3. COVERAGE INVOLVED: _____
4. DATE OF FIRST REPORT: _____
5. POLICY YEAR INVOLVED: _____
6. NATURE OF EVENT GIVING RISE TO LOSS: _____
7. STATUS OF LOSS AS OF THE DATE OF THIS APPLICATION (i.e., Open, Closed with payment, Closed without payment): _____
8. VALUE OF CLAIM AS OF: _____
DATE VALUATION AMOUNT \$ _____
9. "GROUND-UP" LOSS INCURRED (EXCLUDING ADJUSTMENT EXPENSE): \$ _____
 - a) AMOUNT OF LOSS THAT HAS BEEN PAID: \$ _____
 - b) AMOUNT IN RESERVE (NET OF PAYMENTS): \$ _____
10. TOTAL RELATED LOSS ADJUSTMENT EXPENSE: \$ _____
 - a) AMOUNT OF L.A.E. THAT HAS BEEN PAID: \$ _____
 - b) AMOUNT IN RESERVE (NET OF PAYMENTS): \$ _____
11. PAGE _____ OF _____ PAGES.