



# Negley Associates

Behavioral Healthcare,  
Addiction & Social Services

PO Box 134  
Roseland, NJ 07068  
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[www.jjnegley.com](http://www.jjnegley.com)

## Directors & Officers Liability Including Employment Practices Liability Application

1. Proposed Insured \_\_\_\_\_

2. Mailing Address:

Street \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ Phone # \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Fax # \_\_\_\_\_

Website \_\_\_\_\_ Contact \_\_\_\_\_

3. Current Directors & Officers Liability Insurance:

Insurance Company \_\_\_\_\_ Premium \_\_\_\_\_

Limit of Liability \_\_\_\_\_ Deductible \_\_\_\_\_

Policy term: Effective date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Retroactive Date \_\_\_\_\_

4. Limit of liability requested     \$1,000,000     \$2,000,000     \$3,000,000     \$4,000,000     \$5,000,000

5. Has any company cancelled or declined to renew insurance?     Yes     No

If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

6. Year organization founded \_\_\_\_\_

7. Projected annual operating budget \$ \_\_\_\_\_ **(Include current Audited Financial Statement)**

8. Is your organization non-profit?     Yes     No    If no, what is the organization's legal structure?

\_\_\_\_\_  
\_\_\_\_\_

9. Indicate the detailed purpose and description of business activities of the entity:

\_\_\_\_\_  
\_\_\_\_\_

10. Scope of operations:       Local       State       Regional       National       International

11. Give number of directors \_\_\_\_\_ officers \_\_\_\_\_ trustees \_\_\_\_\_  
full time employees \_\_\_\_\_ part time employees \_\_\_\_\_ volunteers \_\_\_\_\_

12. Does the entity or any of its subsidiaries perform or conduct any type of peer review, professional assessment, certification, accreditation or designation of its members?       Yes       No      If yes, please explain (Attach separate sheet if necessary)

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13. Does the organization have any subsidiaries?       Yes       No      If yes, please list (Attach separate sheet if necessary)

Name	Nonprofit For Profit	Nature of Operations	% of Ownership
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14. Are you currently considering the acquisition or creation of any subsidiaries?       Yes       No      If yes, please explain. Explanation should include information as requested in #13. (Attach separate sheet if necessary)

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15. Does the organization have any current EEOC complaints pending?       Yes       No

16. In the past five (5) years, have any claims been made or are there any now pending against the entity, or any person proposed for this insurance?       Yes       No

17. Does the entity or its directors, officers, trustees or employees have any knowledge of pending federal, state, or local actions or proceedings against them, or in the past five(5) years have they been involved in any federal, state, or local actions or proceedings?       Yes       No

18. Is any person proposed for this insurance aware of any fact, circumstance or situation which could reasonably be expected to give rise to any future claim?       Yes       No

*(If any or all of questions 15, 16, 17 or 18 are answered yes, please attach a separate sheet explaining the facts, circumstances or situations for each. Any claim or action arising out of such facts, circumstances or situations is excluded from the proposed coverage.)*

**Very Important** – Please attach copies of organization By-Laws and a list of the Board of Directors.

This application does not bind you nor us to complete the insurance, but it is agreed this form will be the basis of the contract should a policy be issued. This form will be attached to and become a part of this policy.

**FRAUDWARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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.

SIGNATURE: \_\_\_\_\_ TITLE: \_\_\_\_\_  
(Must be signed by Executive Director, President, CEO, CFO or Chairperson of the Board)

\_\_\_\_\_  
(Please print or type name) DATE: \_\_\_\_\_

Please retain a copy of the completed application. A copy with the required signature must be returned to our office.

**PRODUCER:** Will you make the surplus lines filing for this policy? \_\_\_\_ Yes \_\_\_\_ No  
Your Surplus Lines License Number \_\_\_\_\_ ( )

## NOTICE TO CALIFORNIA INSURED

**1. THE INSURANCE POLICY THAT YOU [HAVE PURCHASED] [ARE APPLYING TO PURCHASE] IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**

**2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**

**3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**

**4. THE INSURER SHOULD BE LICENSED EITHER AS A FOREIGN INSURER IN ANOTHER STATE IN THE UNITED STATES OR AS A NON-UNITED STATES (ALIEN) INSURER. YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357. ASK WHETHER OR NOT THE INSURER IS LICENSED AS A FOREIGN OR NONUNITED STATES (ALIEN) INSURER AND FOR ADDITIONAL INFORMATION ABOUT THE INSURER. YOU MAY ALSO CONTACT THE NAIC’S INTERNET WEB SITE AT [WWW.NAIC.ORG](http://WWW.NAIC.ORG).**

**5. FOREIGN INSURERS SHOULD BE LICENSED BY A STATE IN THE UNITED STATES AND YOU MAY CONTACT THAT STATE'S DEPARTMENT OF INSURANCE TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.**

**6. FOR NON-UNITED STATES (ALIEN) INSURERS, THE INSURER SHOULD BE LICENSED BY A COUNTRY OUTSIDE OF THE UNITED STATES AND SHOULD BE ON THE NAIC'S INTERNATIONAL INSURERS DEPARTMENT (IID) LISTING OF APPROVED AGENT, BROKER, OR "SURPLUS LINE" BROKER TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.**

**7. CALIFORNIA MAINTAINS A LIST OF APPROVED SURPLUS LINE INSURERS. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEBSITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: [WWW.INSURANCE.CA.GOV](http://WWW.INSURANCE.CA.GOV).**

**8. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

(California D-2)