



First Nonprofit<sup>®</sup>  
Mutual Insurance Company

*Owned by, governed by and dedicated  
to the nonprofit community since 1978.*

111 North Canal Street, Suite 801  
Chicago, Illinois 60606  
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Fax: 312.930.0375

## I. Nonprofit General Profile Questionnaire

This questionnaire provides us with general information about your submission that is not included on the Acord form and will help you to determine which additional questionnaires to complete.

\_\_\_\_\_  
Name of organization

\_\_\_\_\_  
Mailing address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone Fax URL/Web site

\_\_\_\_\_  
Executive Director Phone Email

\_\_\_\_\_  
Insurance Contact Phone Email

\_\_\_\_\_  
Loss Control Contact Phone Email

Number of Years in Business \_\_\_\_\_ Is your organization 501(c)3?  Yes  No

Estimated Annual Payroll \_\_\_\_\_ Revenue \_\_\_\_\_ Expenses \_\_\_\_\_

Description of Operations (Please attach brochures, annual report or newsletters.)

List the number of locations and brief description of occupancy per location.

List professional organizations, associations or accreditations. (Please explain by attaching a separate sheet if necessary.)

If your licensing or accreditation has ever been revoked, suspended or denied, describe.

If your property, liability, auto or professional insurance has been cancelled or non-renewed in the past three years, please describe.

**Human Resources Questions**

Organizational Staffing Profile		Employees		Volunteers		Independent Contractors	
		FT	PT	FT	PT	FT	PT
Executive/Administrative							
Clerical/Data Entry/Filing							
Maintenance/Service/Janitorial							
Drivers							
Interns							
Social Workers, degreed							
Counselors							
Residential On-Site Property Staff							
Teachers:	Montessori/Preschool						
	K – 8 <sup>th</sup> grade						
	9 <sup>th</sup> – 12 <sup>th</sup> grade						
Aides:	Montessori/Preschool						
	K – 8 <sup>th</sup> grade						
	9 <sup>th</sup> – 12 <sup>th</sup> grade						
Therapists:	Speech						
	Occupational						
	Physical						
RNs/LPNs							
Psychologists							
Phlebotomists							
Medical Doctors							
Psychiatrists							
Homemaker Services							
Other (Describe)							
Total Number							

What is your annual staff turnover rate? \_\_\_\_\_

What is the average pay for professional employees? \_\_\_\_\_ Non-professional employees? \_\_\_\_\_

Does each staff member have a written job description?  Yes  No

<b>Prior to hire do you obtain the following:</b>	Employees	Volunteers	Independent Contractors
Application for employment			
Check personal/business references			
Education credentials			
Motor vehicle records			
Conduct criminal background check			
State or governmental regulatory authority screening			
Pre-employment background check			
Keep investigation records in personnel files			

Does your organization have orientation program for all staff?  Yes  No

**Organization Questions**

<b>After hire, do you provide the following staff training?</b>	Employees	Volunteers	Independent Contractors
Organization policies and procedures			
Job responsibilities			
Emergency procedures			
Driver training and safety			
Emergency procedures including first aid and evacuations			
How to recognize signs of physical/sexual abuse			

Does your organization utilize any services of independent contractors?  Yes  No  
(i.e. professional staff, medical staff, transportation services, caterer, etc.)

**If yes, complete the following for each exposure and attach a separate sheet if necessary.**

Do your independent contractors have a signed written agreements specifying status as independent contractors and not employees?  Yes  No

Does the contract specify services to be provided?  Yes  No

Do they provide you with certificate of insurance providing proof of insurance for services rendered?  Yes  No

Are minimum limits of coverage requested? If so, what are minimum limits?  Yes  No

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

Does the independent contractor's insurance list your organization as additional insured?  Yes  No

How often do you update certificate? \_\_\_\_\_ Verify license of provider? \_\_\_\_\_

**Operations and Exposures**

<b>If...</b>	<b>Complete Questionnaire #</b>
you need professional coverage for your professional staff including social workers, counselors, therapists, psychologists and teachers.	2
you need coverage for medical professionals in your incidental medical exposures.	2
you need sexual abuse coverage	3
you have a non-owned or hired automobile exposure.	4
you operate any residential facility, group homes, or apartments.	5
you operate any child care, day care, Montessori, or head start programs.	6
you sponsor any fundraisers or special events	7
you have any builders risk, renovations or rehabilitation work in progress at any location.	8
you operate a sheltered workshop or vocational training program.	9
you operate a recreation center, camp, swimming pool, scuba program or offer horsebackriding.	10
you have any other recreation activities.	10
you have any operations involving foster care or adoptions.	11
you need workers' compensation coverage	12

**In order to better evaluate your exposures, please provide the following information**

- Brochure, annual report, newsletters**
- Loss history for 3-5 years**
- Audited fiscal year end financial statement**

**This form has been completed by:**

\_\_\_\_\_  
Name:

\_\_\_\_\_ Title: \_\_\_\_\_ Date:

**This account has been submitted by:**

\_\_\_\_\_  
Producer Name

\_\_\_\_\_  
Insurance Agency

\_\_\_\_\_  
Address

\_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number

\_\_\_\_\_  
Email

**Notes:**