VaRISK 2 APPLICATION FOR MEALS ON WHEELS ORGANIZATIONS & AREA AGENCIES ON AGING

This application is for Meals on Wheels organizations and area agencies on aging eligible to enroll in the **Virginia Liability Risk Management Plan** (VaRISK 2) pursuant to § 2.2-1839, *Code of Virginia*.

Virginia Division of Risk Management
PO Box 1879 ~ Richmond VA 23218-1879
1-800-678-4924 ~ FAX 804-371-8400

A. Legal Name of Organization

_____

Street Address

_____

City, State, Zip

_____

Telephone (_____)_____ FAX (_____)_____

Email address _____

NOTE: If organization has more than one location, attach list of all location addresses, telephone numbers, and other contact information.

B. Budget (For current fiscal year). Fiscal Year _____

Revenues $_____ Expenditures $_____

(Attach copy of incorporation papers, current budget or annual financial statement)

C. Does your organization administer any other program other than the providing of meals to persons registered? Yes ___ No ___

(If yes, attach full description, incorporation papers, and budget of each operation or program.)

D. Does your organization carry Commercial General Liability ___ Directors & Officers / Errors & Omissions ___ Medical Malpractice ___ or Umbrella Liability insurance ____?

(Check all that apply and attach copies of declaration sheet of each policy carried listing company, insured, type of policy, and limits.)

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E. How many meals are served annually? _____

F. 1. Has any employee, volunteer or job applicant made a claim alleging unfair or improper treatment regarding hiring, remuneration, advancement or termination of employment? Yes___ No ___

2. Has the organization been sued regarding discrimination, the Americans with Disabilities Act, sexual harassment or other civil rights claims? Yes ___ No ___

G. Number of employees and volunteers other than licensed health care practitioners:

Full Time _____ Part Time _____ Volunteers _____

H. Is your organization affiliated contractually with any other organization? Yes___ No ___

(If yes, separately list the type of contract, the organization, and its address. You may be asked to submit a copy of specific contracts prior to enrollment.)

I. Print the name and title of the person designated to receive all information regarding the **VaRISK 2** plan at the address listed in Section A.

Name _____ Title _____

Telephone (____)_____ Email Address _____

The UNDERSIGNED (signature of person named in Section I above) certifies that all information provided herein is accurate:

Signature _____ Date _____

NOTE: Application must be completed in full and submitted with all necessary attachments before a quote for coverage can be provided.