

D&O BUILDING/RENOVATION SUPPLEMENTAL QUESTIONNAIRE

Please complete this questionnaire in it's entirety

Association Name:

(Must be completed)

1. Type / purpose of building renovation?
2. Estimated cost of building renovation?
3. Is a special assessment needed to fund renovations?
 Yes No. Adequate funds available
If adequate funds are available, what percentage of reserves will be used?

If an assessment is required will unit owners vote on it? Yes No
If a vote has transpired, what was the date of the vote and the outcome?
If no vote is required, why not?
4. What was the process for selecting a contractor?
Is the contractor properly bonded/licensed? Yes No
Is insurance in place that adds the Association as an insured or is there a hold harmless or similar indemnity agreement in place? Yes No
5. Are renovations for....
 Safety and structural soundness
 Aesthetics
 Compliance with applicable law
 Other
6. Most local laws require that renovations/structural changes comply with the American Disabilities Act. Have appropriate steps been taken to ensure compliance?
 Yes No Please describe.
7. Permits – Does the Board have an established procedure for receiving a copy of the work permit to post in the building or to hold in the office to present if an inspector should visit?
 Yes No

Please provide a copy of the Association's most current financials.

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURANCE COMPANY OR OTHER PERSON FILES THIS QUESTIONNAIRE 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 WHICH MAY RESULT IN CIVIL OR CRIMINAL FINES OR PENALTIES.

KNOWN PRIOR CLAIMS: IT IS UNDERSTOOD AND AGREED THAT THIS POLICY DOES NOT APPLY TO ANY CLAIM BASED UPON, ARISING OUT OF, RELATING TO, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY WRONGFUL ACT OR ANY CIRCUMSTANCES KNOWN BY THE INSURED PRIOR TO THE INITIAL COVERAGE DATE WHICH WOULD INDICATE THE PROBABILITY OF SUCH CLAIM BEING MADE. PLEASE OBTAIN A COPY OF THE POLICY THROUGH YOUR BROKER AND READ IT CAREFULLY.

Agent or Broker Name:

The undersigned, on behalf of all prospective Insureds, declares to the best of his/her knowledge, the statements in this Application and any attachments are true and accurate.

Signature: _____

Title: _____

Date: _____