Strickland
E & S Brokers

SOCIAL SERVICES
PROFESSIONAL LIABILITY APPLICATION for
MENTAL HEALTH / FAMILY COUNSELING SERVICES

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED.
If the answer is NONE, state NONE;
If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A).
If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET.
NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____
1.2 Mailing Address: _____
_____
1.3 Location Address(es): _____
_____
1.4 County (parish) of each location: _____
1.5 Telephone Number: Office (_____)_____ Fax (_____)_____
1.6 Person to contact for Survey: Name: _____Title:
1.7 Year entity established: _____
1.8 The Applicant is (Please check and complete A) of B) below:
_____ A. The **APPLICANT** is an INDIVIDUAL. If so, the INDIVIDUAL is an:
__ Employee (W-2) __ Student __ Ind. Contr. (1099) __ Sole Practitioner
_____ B. The **APPLICANT** is a:
__ Sole Proprietorship __ Partnership __ Corporation
__ Other - Describe:_____
1.9 Entity is _____ For Profit _____ Non-Profit, Describe source of funds: _____
1.10 Proposed Effective Date: _____
1.11 Requested Limits of Liability (if available): $_____/$ _____
Is General Liability coverage also desired? _____ No _____ Yes
1.12 Annual Gross Receipts: Estimated next twelve months - $_____
Last twelve months - $_____
1.13 Number of Patient Encounters: Next 12 months: _____ Last 12 months _____
1.14 Premises Square Footage Area occupied by applicant: _____ Are any off premises services provided? If yes, describe:_____
_____

PART II. EXPOSURES

2.1 Service is licensed as _____
2.2 Describe the nature of insured's operation including types of services rendered and activities conducted: ___
_____
_____

2.3 Describe any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction. _____

2.4 (a) Does applicant conduct group therapy sessions which exceed four (4) hours in duration, or more than 25 patients/clients any one occasion? ___ No ___ Yes IF YES, give frequency and length of sessions, and # patients/clients: _____(b) Does applicant conduct any seminars, workshops or other "group activities" away from regular office premises (including teaching seminars for fellow professionals) _____ No _____ Yes IF YES, give frequency of seminars and # participants/attendees. _____

2.5 Does applicant sell, rent or otherwise distribute any products (including any records, audio tapes, video tapes, films, etc.) ___ No ___ Yes IF YES, describe and give est. receipts.

2.6 Does applicant utilize any of the following modalities in the treatment of more than 50% of applicant's patients/clients.

A) Hypno Therapy ___ No ___ Yes If yes, ___%
B) Biofeedback ___ No ___ Yes If yes, ___%
C) Kinesthetics ___ No ___ Yes If yes, ___%
D) Psychodrama ___ No ___ Yes If yes, ___%
E) Bioenergetics ___ No ___ Yes If yes, ___%

2.7 Does applicant routinely (more than twice in last three years) provide testimony in:

1) Child custody hearing ___ No ___ Yes If Yes, # times 3 yrs _____
2) Competency hearings ___ No ___ Yes If Yes, # times 3 yrs _____
3) As an expert witness in criminal or civil trials or other legal proceeding ___ No ___ Yes If Yes, # times 3 yrs _____

2.8 Does applicant assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying or apprehending criminal offenders? ___ No ___ Yes
IF YES, describe and give frequency _____

2.9 Does applicant's practice involve the following: **If Yes, give % of practice**, by income, hours or # clients.

Child/pediatric therapy ___ No ___ Yes If yes, ___%
Criminal offender therapy/evaluation ___ No ___ Yes If yes, ___%
Therapy for victims of criminal sexual abuse ___ No ___ Yes If yes, ___%
Therapy for substance abusers ___ No ___ Yes If yes, ___%
Crisis Intervention ___ No ___ Yes If yes, ___%
Therapy for sexual response/disfunction ___ No ___ Yes If Yes, ___%

2.10 Does applicant's practice involve the following: If YES, give % of practice, and number of clients treated in the last three years. Diagnosis / treatment of:

"Failed/Repressed" Memory Syndrome ___ No ___ Yes If Yes, ___% _____ # clients 3 yrs
Multiple Personality Disorder ___ No ___ Yes If Yes, ___% _____ # clients 3 yrs

2.11 Are any of applicant's patients/clients referred (or remanded) by courts of law or attorneys or other legal representatives of the patient/client? ___ No ___ Yes IF YES, give % of patients._____

2.12 **Unless otherwise noted hereunder**, the following are true statements with regard to the applicant:

a) Applicant, including employees and independent contractor, is not a principal with any healthcare related partnership, association or corporation, nor is applicant a proprietor, superintendent, officer, director, stockholder or member of the board of directors, trustees, or governors of any healthcare related business enterprise;

b) Applicant does not provide billing or collection services for any other professional person or organization;

c) Applicant does not share staff with any other professional person or organization;

d) Applicant does not share office premises with any psychiatrist or any other physician;

e) Applicant, including employees and independent contractors, is not licensed or authorized to provide any other professional services except as stated in application;

f) Applicant, including employees and independent contractors, has never had his/her license or

certification revoked or suspended, not been the subject of any disciplinary proceeding, not been reprimanded by an administrative agency, professional association or peer committee;

g) Applicant, including employees and independent contractors has never had a claim or suit brought against him/her because of any alleged malpractice, error or mistake arising out of his/her professional services, and applicant is not aware of any circumstances which might result in such a claim or suit.

EXCEPTIONS, if any, to above (absence of entry means "no exceptions"):_____

_____

_____

PART III. RISK MANAGEMENT

3.1 Please list all professional staff including degrees held, professional designation:

a) Salaried Employees (W-2) _____

_____

b) Independent Contractors (1099) _____

_____

c) Interns (W-2 or 1099) _____

_____

d) Professional Associates Sharing Premises _____

_____

3.2 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf?

__ No __ Yes

If no, do you require contracted staff (if any) to carry their own Professional Liability Insurance?

__ No __ Yes

Do you secure Certificates of Insurance as evidence of such coverage? __ No __ Yes

3.3 List all memberships in professional organizations. _____

_____

3.4 Do you enter into contractual agreements to provide professional services? __ No __ Yes

IF YES, enclose copies of all such contracts.

Do you provide services under contract, with said services billed by the other party in lieu of you billing direct for your services? ____ No ____ Yes If Yes, identify contract and services provided:

_____

_____

_____

3.5 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? __ No __ Yes

If not, are you agreeable to instituting this procedure? __ No __ Yes

ENCLOSE COPY OF YOUR LETTERHEAD, BROCHURES, ADVERTISING.

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, with the most recent year. If none, so state.

Insurer Number	Policy Liability	Limits of Premium	Eff. Date	Claims-Made Form No	Yes
1.					
2.					
3.					
4.					
5.					

If claims-made, what is the most recent retroactive date?_____

4.2 List prior general liability insurers for the past five years, with the most recent year. If none, so state.

Insurer Number	Policy Liability	Limits of Premium	Eff. Date	Claims-Made Form No	Claims-Made Form Yes

1._____
2._____
3._____
4._____
5._____

If claims-made, what is the most recent retroactive date?_____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?

___ No ___ Yes IF YES, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary)._____

_____

_____

_____

_____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?

___ No ___ Yes IF YES, describe the event and indicate the reason for anticipation of a claim. _____

_____

_____

_____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

_____ _____

Date Applicant/Title