OUTPATIENT MENTAL HEALTH COUNSELING PROFESSIONAL AND GENERAL LIABILITY APPLICATION

1. Name of Applicant:
   _____

2. Mailing Address:
   _____

3. Location Address:
   _____
   (If multiple name and locations, please attach list)

4. Telephone Number: _____ Fax Number: _____

5. Date Established: _____

   a. Entity Type: Corp. ☐ Partnership ☐ Prof. Assoc. ☐ Individual ☐
   b. For Profit ☐ Non-Profit ☐

6. Desired Effective Date: _____

   a. Desired Limits of Liability: $_____ / $_____
   b. Desired Deductible: $_____

7. Gross Receipts for Past 12 Months: $_____

   a. Est. Gross Receipts for Next 12 Months: $_____
   b. Payroll for Past 12 Months: $_____
   c. Est. Payroll for Next 12 Months: $_____
   d. Number of Visits for Past 12 Months: _____
   e. Est. Number of Visits for Next 12 Months: _____

8. Applicant's Service is licensed as a: _____

9. Full description of services provided: _____

10. Does the applicant have any ancillary operations not stated above? Yes ☐ No ☐

    If yes, please provide details:
    _____

11. Is the firm engaged in, owned by, associated with, or controlled by any other business? If yes, please provide details:
    _____

12. Are all services provided at the applicant's location address(s)? Yes ☐ No ☐
    If no, please provide details of any off-site exposure:
    _____

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

14. Please provide a breakdown of the types of counseling services provided & exposures below:
Substance Abuse (Alcohol/Drugs) _____ % Ex-Offender Therapy/Evaluation _____ %
Crisis Intervention _____ % Family _____ %
Marriage _____ % General _____ %
Child/Pediatric _____ % Victims of Domestic/Sexual Abuse _____ %
Other; Describe:
_____

15. Does the applicant use hypnotherapy, treat for failed/repressed memory syndrome, or use any alternative/nontraditional counseling methods as part of their practice? Yes ☐ No ☐

If yes, please provide details of methods used & what % this is of their total operation:
_____
_____
_____

16. Does the applicant do any of the following:

Provide testimony in child custody hearings?
Yes ☐ No ☐ If yes, number of times in past 3 years: _____

Provide testimony in competency hearings?
Yes ☐ No ☐ If yes, number of times in past 3 years: _____

Act as an expert witness in criminal/civil trials or other legal proceedings?
Yes ☐ No ☐ If yes, number of times in past 3 years: _____

Treat patients referred/remanded by courts of law or attorneys or other legal representative of the patient?
Yes ☐ No ☐ If yes, give % of patients: _____

17. List the number and type of applicant's employees estimated over the next 12 months.
If none, state none.

Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Social Worker	_____	Counselor	_____
Nurse Practitioner	_____	Medical Technician	_____
Physician Assistant	_____	Psychiatrist	_____
Paramedic/EMT	_____	Clerical/Admin	_____
Psychologist	_____	Other (please describe)	_____

a. List the number and type of independent contractors estimated over the next 12 months.
If none, state none.

Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Social Worker	_____	Counselor	_____
Nurse Practitioner	_____	Medical Technician	_____
Physician Assistant	_____	Psychiatrist	_____
Paramedic/EMT	_____	Clerical/Admin	_____
Psychologist	_____	Other (please describe)	_____

b. Are all the individuals listed in response to Q17a & b licensed in accordance with applicable state and federal regulations?
Yes ☐ No ☐ If no, attach explanation.

18. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?
Yes ☐ No ☐ If yes, at what limits? $_____ / $_____

If not, is coverage desired with shared limits on this policy? Yes ☐ No ☐

19. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists, or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?
Yes ☐ No ☐ If yes, at what limits? $_____ / $_____

20. Does the applicant provide any beds for overnight stays?
If yes, give details:
_____
_____

21. Do you sell, rent, or otherwise provide any equipment to products or others? If yes, give details including types of products & gross receipts from each:
_____
_____

22. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician?
Yes ☐ No ☐ If no, give details: _____
_____

23. Do you conduct pre-employment screenings and investigations? Yes ☐ No ☐
a. Do you question prospects about previous claims or suits? Yes ☐ No ☐
b. Are employees required to actively participate in continuing education? Yes ☐ No ☐
c. Do you prepare job descriptions and instructional manuals for your staff? Yes ☐ No ☐
d. Do you have a written incident/occurrence reporting policy and procedures? Yes ☐ No ☐

24. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications	_____	Criminal Background Checks	_____
Drug / HIV/ Hepatitis Testing	_____	Licenses Held	_____
Education/Training/Competence	_____	Multi-State Registry	_____

25. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:
_____
_____

26. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:
Has the applicant or have any of the above employees:

a. Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?
Yes ☐ No ☐
b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

c. Ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

27. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?
Yes ☐ No ☐ If yes, give details, including name, location size and number of beds: _____
_____

28. Do you provide any legal and/or financial services or handle client's money, bills, or finances of any type?
Yes ☐ No ☐ If yes, please provide details: _____

29. Do you act as legal guardian or power of attorney for anyone? Yes ☐ No ☐

If yes, please provide details: _____

30. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

a. If expiring insurance is a claims made policy, what is the retroactive date?
_____

31. Give General Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

a. If expiring insurance is a claims made policy, what is the retroactive date?
_____

32. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused? Yes ☐ No ☐
If yes, please give details: _____

33. Has any insurer cancelled or refused to renew any similar insurance during the past five years?
Yes ☐ No ☐

If yes, please give details: _____

34. Has any claim ever been made against the firm or any of its employees?
Yes ☐ No ☐
If yes, please attach details stating:
Date when claim was made, Date the act giving rise to the claim was committed, Name of the claimant, Nature of the claim amount involved including reserves, and Final disposition.

35. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?
Yes☐ No☐

If yes, please give details: _____

Application for Claims-Made Professional Liability Insurance The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

_____

Applicant Name Title

_____

Date Applicant Signature Title

(NOTE: Application must be signed by the owner or president or principal)