



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; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

- 1 Applicant Name: _____
- 2 Mailing Address: _____

- 3 Location Address(es): _____

- 4 County (parish) of Each Location: _____

- 5 Telephone Number: Office: _____ Fax: _____
- 6 Person to Contact for Survey: Name: _____ Title: _____
- 7 Date Established: _____
- 8 The applicant is: Partnership
 Sole Practitioner Corporation
 Sole Proprietorship Other; Describe: _____
- 9 Entity is: For Profit Non-Profit
Describe source of funds: _____

PART II. EXPOSURES

- 10 Annual Gross Receipts or Budget: Estimated Next 12 Months: \$ _____
Last 12 Months: \$ _____
- 11 Number of Patient Encounters: Next 12 Months: _____ Last 12 Months: _____
- 12 Premises Square Footage Area Occupied by Applicant: _____
Are any off-premises services provided? If yes, describe: _____

- 13 Is the facility Licensed? [] Yes [] No
 If no, explain: _____

- 14 Service is licensed as: _____
- 15 Describe the nature of insured's operation including types of services rendered and activities conducted: _____
- 16 Describe any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction: _____

- 17 (a) Does applicant conduct group therapy sessions which exceed four (4) hours in duration or more than 25 patients/clients any one occasion? [] Yes [] No
 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)? [] Yes [] No
 If yes, give frequency of seminars and # of participants/attendees: _____
- 18 Does applicant sell, rent, or otherwise distribute any products (including any records, audio tapes, video tapes, films, etc.)? [] Yes [] No
 If yes, describe and give est. receipts: _____
- 19 Does applicant utilize any of the following modalities in the treatment of more than 50% of applicant's patients/clients?
- | | | | |
|---------------|----|-----|----------------|
| Hypno Therapy | No | Yes | If yes, _____% |
| Biofeedback | No | Yes | If yes, _____% |
| Kinesthetics | No | Yes | If yes, _____% |
| Psychodrama | No | Yes | If yes, _____% |
| Bioenergetics | No | Yes | If yes, _____% |
- 20 Does applicant routinely (more than twice in last three years) provide testimony in:
- | | | | |
|-----------------------|----|-----|-----------------------------|
| Child Custody Hearing | No | Yes | If yes, # times 3 yrs _____ |
| Competency Hearings | No | Yes | If yes, # times 3 yrs _____ |
- As an expert witness in criminal or civil trials or other legal proceeding? [] Yes [] No
 If yes, # times 3 yrs: _____
- 21 Does applicant assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying, or apprehending criminal offenders? [] Yes [] No
 If yes, describe and give frequency: _____

- 22 Does applicant's practice involve the following? If yes, give % of practice, by income, hours, or # of 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/dysfunction | No | Yes | If yes, _____% |
- 23 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, # times 3 yrs _____ |
| Multiple Personality Disorder | No | Yes | If yes, # times 3 yrs _____ |
- 24 Are any of applicant's patients/clients referred by courts of law or attorneys or other legal representatives of the patient/client? [] Yes [] No
 If yes, give % of patients: _____

PART III. RISK MANAGEMENT

- 25 Please list all professional staff including degrees held and professional designation:
- a) Salaried Employees (W-2): _____

 - b) Independent Contractors (1099): _____

 - c) Interns (W-2 or 1099): _____

 - d) Professional Associates Sharing Premises: _____

- 26 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? [] Yes [] No
 If no, do you require contracted staff (if any) to carry their own professional liability insurance? [] Yes [] No
 Do you secure Certificates of Insurance as evidence of such coverage? [] Yes [] No
- 27 List all memberships in professional organizations: _____
- 28 Do you enter into contractual agreements to provide professional services? [] Yes [] No
 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? [] Yes [] No

If yes, identify contract and services provided: _____

- 29 Do you require staff to report all incidents (accidents) that might result in a liability claim, are records of such reports kept on file by you? Yes No
 If not, are you agreeable to instituting this procedure? Yes No

Enclose copy of your letterhead, brochures, and advertising.

- 30 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 health care-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 health care-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 aware of any circumstances that might result in such a claim or suit.

Exceptions, if any, to above (no answer means "no exceptions"): _____

PART IV. HISTORY

- 31 List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date? _____

32 List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date? _____

33 Requested Limits of Liability (if available):

Professional Liability \$ _____ Each Medical Incident/ \$ _____ Aggregate

General Liability \$ _____ Each Occurrence/ \$ _____ General Aggregate

34 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? [] Yes [] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

35 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? [] Yes [] No

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 JaVA Underwriting, LLC, 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 dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

Applicant Signature

Title

Date

Mental Health Practitioners Exceptions Supplement (Individual Coverage)

Unless otherwise noted hereunder, the following are true statements applicable to the insured:

- a) Insured does not conduct group therapy sessions which exceed four (4) hours in duration;
- b) Insured does not conduct any seminars, workshops, or other "group activities" away from his/her regular office premises that involve more than twenty-five (25) patients/clients in any one occasion;
- c) Insured does not sell, rent, or otherwise distribute any products (including but not limited to any records, audio tapes, videotapes, films);
- d) Not more than twenty-five percent (25%) of the insured's practice (by income, hours, or # of clients) involves: i) criminal or sex abuse offender therapy or evaluation, or ii) therapy for victims of sex abuse;
- e) Insured does not routinely (more than five in last three years) provide testimony i) in child custody hearings, ii) in competency hearings, iii) as an expert witness in legal proceedings;
- f) Insured does not assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying, or apprehending criminal offenders;
- g) Not more than fifty percent (50%) of insured's practice (by income, hours of service, or number of patients/clients) involves the following:
 - i) child/pediatric therapy
 - ii) therapy for substance abusers
 - iii) crisis intervention
 - iv) therapy for sexual response/dysfunctionor the following modalities in treatment
 - v) hypnotherapy
 - vi) biofeedback
 - vii) kinesthetics
 - viii) psychodrama
 - ix) bioenergetics;
- h) Insured's practice does not involve treatment for dissociative disorder not otherwise specified, commonly referred to as "false memories disorder" or "repressed memory disorder;"
- i) Insured's practice does not involve treatment for dissociative identity disorder (multiple personality disorder);
- j) Not more than twenty-five percent (25%) of insured's patients/clients are referred (or remanded) by courts of law or attorneys or other legal representatives of the patient/client;
- k) Insured does not provide billing or collection services for any other professional person or organization;
- l) Insured does not share office premises with any psychiatrist or any other physician;
- m) Insured is not licensed or authorized to provide any other professional services;

- n) Insured has never had his/her license or certification revoked or suspended, nor been the subject of any disciplinary proceeding, nor been reprimanded by any administrative agency, professional association, or peer committee;
- o) Insured 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 insured is aware of any circumstances that might result in such a claim or suit.

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