PROFESSIONAL LIABILITY APPLICATION
FOR SOCIAL SERVICES
WITH NO RESIDENTIAL EXPOSURE

INSTRUCTIONS: ANSWER ALL QUESTIONS; IF THE ANSWER IS NONE, STATE NONE; IF THE QUESTION 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:_____

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 Proposed **Effective Date**:_____Year Entity Established:_____

1.8 The Applicant is (Please check and complete A) or B) below:

___ A. The **APPLICANT** is an INDIVIDUAL:

IF SO, the INDIVIDUAL is an ___ Employee ___ Student ___ Sole Practitioner

___ B. The **APPLICANT** is a:

___ Sole Proprietorship ___ Partnership ___ Corporation

___ Other - Describe _____

1.9 Entity is ___ For Profit ___ Not-for-Profit. Describe source of funds:_____

1.10 Requested Limits of Liability (if available):

Professional Liability $_____each medical incident/$_____aggregate

General Liability $_____each occurrence/$_____general aggregate

1.11 Annual Gross Receipts or Budget: Estimated next twelve months - $_____

last twelve months - $_____

1.12 Annual Payroll or Remuneration: Estimated next twelve months - $_____

last twelve months - $_____

1.13 Type of Facility: (Licensed?___Yes ___No If NO, Explain:_____)

Check One, or describe:

___ Adoption Agency *

___ Child Day Care *

___ Day Care (Senior Citizens) *

___ Day Care (Senior Citizens) *

___ Foster Care *

___ Hotlines (Phone Crisis Service)

___ Meals on Wheels

___ Nanny Services

___ Employee Assistance Program

___ Referral Agency * (Consultants Supplement)

___ Sheltered Workshop *

___ Other:_____

_____

* Applicable supplemental questionnaire must be completed

1.14 Describe the nature of insured's operation including types of services rendered and activities conducted:_____

_____

1.15 List memberships in professional organizations._____

1.16 Is the applicant/facility and all professional employees licensed in accordance with applicable state and federal laws? ___Yes ___ No If No, Explain:_____

PART II. EXPOSURES

2.1 Does facility provide **"Day"** services? ____Yes ____ No If Yes, what is the

Number of "day patients" (include "independent living" persons) Maximum # ____ Average # ____

2.2 Do you conduct a **Sheltered Workshop**? ____ Yes ____ No If Yes, the application for Sheltered Workshops for Retarded and Developmentally Disabled Persons must be completed.

2.3 Are all patients fully ambulatory (including use of cane or walker)? ___ Yes ___ No

If not, explain:_____

2.4 What was your total number of outpatient/client visits last year?_____ Estimated next year?_____

2.5 Do you conduct group therapy sessions? ___ Yes ___ No If Yes, do any sessions exceed four (4) hours in duration? ___ Yes ___ No If Yes, how many annually? _____

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

2.7 Describe any services specifically concerned with sexual response/dysfunction of individual patients/clients:_____

2.8 Is there a Registered Nurse on duty? ___ Yes ___ No If Yes, how many shifts per day? _____

2.9 Is any medication prescribed? ___ Yes ___ No If Yes, list names and frequency:_____

_____

Are medications stored in a secure manner? ___ Yes ___ No

If No, explain in detail:_____

2.10 Do you enter into any contractual agreements ? __ Yes __ No

IF YES, enclose copies of all such contracts including those contracts for use with patients/clients.

2.11 Enclose a copy of all brochures or advertising materials distributed by you.

2.12 Any activities or events for patients/clients conducted or sponsored __ Yes __ No

away from applicants? IF YES, describe_____

2.13 Any swimming pools, exercise facilities, or athletic activities? __ Yes __ No

IF YES, please describe (for pool give info re pool use rules, life guard, fencing, depth)_____

_____

2.14 Describe any "fund raising" or other special events activities conducted._____

2.15 Do you have any other premises or operations not stated in this application? __ Yes __ No

IF YES, enclose complete description/locations of operations and insurance information.

PART III. RISK MANAGEMENT

3.1 Do you require employees to report all incidents (accidents)? __ Yes __ No

Are records of such reports kept on file by the facility? __ Yes __ No

If no, explain:_____

3.2 Are precautions taken to prevent patients/clients leaving premises or “wandering” without applicant’s knowledge, such as exit alarms, etc.? ____ Yes ____ No Describe: _____

_____

3.3 Is there a written emergency evacuation plan? __ Yes __ No

3.4 State the frequency of fire drills: _____

3.5 Does the applicant/facility have personnel trained in emergency medical care in the facility during all hours of operation? __ Yes __ No

Please describe:_____

_____

3.7 Explain arrangements for medical emergencies (i.e. physician on call, transfer arrangement with hospital, etc.)_____

_____

3.8 Number of **Professional Staff**: (**E = Employed** **C = Contract**)

E	C		E	C	
__	__	Dieticians/Nutritionists	__	__	Physiotherapists/Physical Therapists
__	__	Occupational Therapists	__	__	Psychologists/Psychotherapists
__	__	Pharmacists	__	__	Psychiatrist *
__	__	Physician * / Dentist *	__	__	Speech Therapists
__	__	Nurse Practitioner	__	__	RN's / LVN's / LPN's
__	__	Physician Assistant	__	__	Respiratory Therapists
__	__	Social Workers	__	__	Case Managers
__	__	Marriage/Family Counselors	__	__	School Counselors
__	__	Teachers	__	__	Other:_____

Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, Physician Assistants

* Complete Physician Supplement when applicable.

NAME	PROFESSIONAL STATUS	E, C, or I	MAINTAINS OWN MALPRACTICE INS.	LIMIT OF LIABILITY	CERT. OF INS. OBTAINED
		E = Employee C = Contract I = Independent			

3.9 Do you have any physicians on staff admitting patients, or treating patients who have restricted? Licenses?__ Yes ___ No IF YES, explain on separate sheet.

3.10 Name, qualification and number of years of experience of the Medical Director, all managers and supervisors:

Name Title Experience/Training Association Membership

_____

_____

_____

3.11 Does Applicant have written screening and hiring policies and procedures for all prospective**.** employees, independent contractors/consultants and volunteers? __ Yes __ No

If yes, please provide copies of the procedures, including samples of employment applications.

3.12 Are there written guidelines regarding sexual misconduct? __ Yes __ No

If yes, please provide copies of all policies and procedures including training materials.

PART IV. HISTORY

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

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

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

NOTE: If prior acts coverage is needed, complete **Prior Acts** Supplemental application.

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

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

If claims-made form, 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?

___ 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)._____

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?

___ 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 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 that applicant has not withheld any 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