



388 Pompton Avenue, P.O. Box 206, Cedar Grove, NJ 07009  
1-800-845-1209 • (973) 239-9107 • Fax: (973) 239-6241  
[www.jjnegley.com](http://www.jjnegley.com)

# PROFESSIONAL & GENERAL LIABILITY APPLICATION

**APPLICATION  
FOR PROFESSIONAL & GENERAL LIABILITY INSURANCE**

**For this application to be processed in a timely fashion, please answer every question completely.  
If a question is not applicable, please write N/A. Do not leave any space blank.**

1. Name of Insured \_\_\_\_\_
2. Mailing Address:  
Street \_\_\_\_\_ County \_\_\_\_\_  
City \_\_\_\_\_ Phone Number \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Fax Number \_\_\_\_\_  
Website \_\_\_\_\_ Contact \_\_\_\_\_
3. Type of Organization:  
Individual \_\_\_\_\_ Partnership \_\_\_\_\_  
Corporation, for profit \_\_\_\_\_ Corporation, nonprofit \_\_\_\_\_
4. Describe the purpose of the organization (attach brochures) \_\_\_\_\_  
\_\_\_\_\_
5. If more than one Named Insured listed above, please explain the ownership and operational relationships.  
\_\_\_\_\_
6. Number of years in operation \_\_\_\_\_
7. Projected annual operating budget \$ \_\_\_\_\_ **Include current Audited Financial Statement.**
8. Current Insurance:
- | <b>Professional Liability</b>                |                        | <b>General Liability</b>                     |                        |
|--|------------------------|--|------------------------|
| Company _____                                |                        | Company _____                                |                        |
| Inception Date: _____                        | Expiration Date: _____ | Inception Date: _____                        | Expiration Date: _____ |
| Premium \$ _____                             |                        | Premium \$ _____                             |                        |
| Deductible \$ _____                          |                        | Deductible \$ _____                          |                        |
| Limit of Liability \$ _____                  |                        | Limit of Liability \$ _____                  |                        |
| Occurrence Form? _____ or Claims Made? _____ |                        | Occurrence Form? _____ or Claims Made? _____ |                        |
| If Claims Made form, Retroactive Date _____  |                        | If Claims Made form, Retroactive Date _____  |                        |
9. Limits Requested: Professional Liability \$ \_\_\_\_\_ General Liability \$ \_\_\_\_\_
10. Has any company cancelled or declined to renew insurance? (Not applicable to Missouri applicants) \_\_\_\_\_  
If yes, please explain. \_\_\_\_\_
11. Have there been any claims or lawsuits in the last five years? \_\_\_ Yes \_\_\_ No If yes, give details below:  
**Date of Loss    Amount Paid or Reserved    Claimant's Name/Description of Incident** (Attach separate sheet if necessary)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Are there any circumstances known which may give rise to a claim or lawsuit? \_\_\_ Yes \_\_\_ No  
If yes, explain. \_\_\_\_\_

13. Has any license or accreditation ever been suspended, denied or revoked? \_\_\_\_\_
14. Of what professional association(s) is Insured a member in good standing? \_\_\_\_\_
- \_\_\_\_\_

15. Schedule of Employees:

	Number of		
	Full Time	Part Time	Volunteer
Administrators	_____	_____	_____
Clerical	_____	_____	_____
Counselors	_____	_____	_____
Homemakers/Aides	_____	_____	_____
Nurses (LPN)	_____	_____	_____
Nurses (RN)	_____	_____	_____
Nurse Practitioners	_____	_____	_____
Psychologists	_____	_____	_____
Social Workers	_____	_____	_____
Students	_____	_____	_____
Others, please specify _____	_____	_____	_____
_____	_____	_____	_____

16. Schedule of Physician Staff (Volunteer, Contracted, Employed) if none, write "none" \_\_\_\_\_.

Name	Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed (V, C or E)	Carries own Malpractice Insurance	
						Yes	No
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

17. Do you wish physicians to be covered under the Center's policy?  Yes  No
18. Are drugs or medication administered or prescribed?  Yes  No If yes, please explain. \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

19. Is electroshock therapy utilized?  Yes  No If yes, how many per year? \_\_\_\_\_

20. Schedule of Locations: (Attach separate sheet if necessary.)

Loc. No.	Complete Address (including zip code)	Sq. Feet	Type of Services Provided
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

21. List of Additional Insureds: (If none, write "none" \_\_\_\_\_)

Name and Address (including zip code)	Interest
_____	_____
_____	_____
_____	_____

22. Units of Service - The number of units of each service rendered by the facility should be entered below, where appropriate:

Please indicate the number of **Beds**.

Mental Health Inpatient	_____	Group Home	_____
Alcohol/Drug Inpatient	_____	Shelters	_____
Alcohol/Drug Detox.	_____	Independent Living	_____
Halfway House	_____	Foster Care	_____
		Other, please specify	_____

Please indicate the number of **Annual Outpatient or Client Visits**.

Alcohol/Drug Rehab	_____	Counseling	_____
Mental Health	_____	Methadone Doses	_____
		Other, please specify	_____

Please indicate number of **Clients per Day**.

Adult Day Care	_____	Day Treatment	_____
Child Day Care	_____	Sheltered Workshops	_____
Case Management	_____	Other, please specify	_____

Please indicate number of **Calls, Annually**.

Hotline	_____	Information	_____
Referral	_____	Other, please specify	_____

Please indicate number of **Annual Employee Assistance Programs (EAP) Contacts or Visits**.

Assessments	_____	Counseling Visits	_____
Referrals	_____	No. of Companies under Contract	_____

Please indicate number of **Home Health Care Visits**.

Nonprofessional Hours	_____	IV Therapy	_____
Professional Hours	_____	Other, please specify	_____

23. Attach an application supplement for the following classes of service:

Residential or Inpatient	Day Care, Pre-School, Headstart	Methadone/Buprenorphine
Foster Care/Adoption	Sheltered Workshops/Products	

24. Are there any camp, adventure/wilderness, ropes courses, or any type of recreational programs? If yes, please provide descriptive material. \_\_\_\_\_

25. Are there any swimming or boating activities? If yes, please provide details. \_\_\_\_\_

26. **Very Important** — Please attach copies of all available descriptive materials and/or brochures on your operations.

This application does not bind you nor us to complete the insurance, but it is agreed this form will be the basis of the contract should a policy be issued. This form will be attached to and become a part of this policy.

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 subjects such person to criminal and civil penalties.

Signature of Executive Director \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_  
Please print or type name

Person to contact regarding this application \_\_\_\_\_ Phone \_\_\_\_\_

E-mail \_\_\_\_\_

**PRODUCER:** Will you make the Surplus Lines filing for this policy?  Yes  No

Your Surplus Lines License Number \_\_\_\_\_ ( )