



Negley Associates

Behavioral Healthcare,
Addiction & Social Services

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PROFESSIONAL & GENERAL LIABILITY APPLICATION

I. APPLICANT PROFILE

1. Proposed Insured(s): _____

2. Address (physical address only, no P.O. Box):

Street: _____

City: _____ State: _____ Zip: _____

CEO Name: _____ Phone #: _____ Email: _____

CFO Name: _____ Phone #: _____ Email: _____

3. Type of Organization:

- Individual
- Partnership
- Trust
- Corporation, for profit
- Corporation, nonprofit
- Government Facility
- Limited Liability Company (LLC)

4. Number of years in operation: _____

5. Describe the purpose of the organization:

6. Does the proposed Insured act as a Managed Care Organization or Manager of Funds? Yes No

7. Website: _____
(if no website, attach a current brochure)

8. If more than one proposed Insured is listed above, explain ownership and operational relationships:

9. Projected annual operating budget \$ _____
(include current audited financial statement)

10. Has the proposed Insured sold, acquired, and/or dissolved any entity in the last 5 years? Yes No
If yes, provide name of entity and reason below:

Entity	Sold (S) Acquired (A) Dissolved (D)	Reason

11. Does the proposed Insured have any ownership interest in any other partnership, corporation, and/or LLC? Yes No
 If yes, provide the following information:
- A. Name of entity: _____
- B. Type of organization: Non-profit For Profit
- C. Nature of operations: _____
- D. Percentage of the proposed Insured's ownership: _____ %
- E. Has the proposed Insured ever had any proceedings, investigations, or audits instituted against them as a result of their ownership interest? Yes No
- F. Has the proposed insured ever had any claims, incidents or lawsuits instituted against them as a result of their ownership or interest? Yes No
- G. Are you requesting coverage for this affiliated entity? Yes No

II. SERVICES AND PROGRAMS

(select all that apply)

Residential Exposures:

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcohol/Drug Inpatient | <input type="checkbox"/> Alcohol/Drug Social Detox | <input type="checkbox"/> Alcohol/Drug Medical Detox |
| <input type="checkbox"/> Apartments | <input type="checkbox"/> Battered Family | <input type="checkbox"/> Criminal Offenders |
| <input type="checkbox"/> Crisis beds | <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Foster Care | <input type="checkbox"/> Group Home |
| <input type="checkbox"/> Halfway House | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Homeless Shelters |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Independent Living | <input type="checkbox"/> Juvenile Residential |
| <input type="checkbox"/> Lockdown Facilities | <input type="checkbox"/> Mental Health Inpatient | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Senior/Adult Home | <input type="checkbox"/> Sexual Offender Treatment | <input type="checkbox"/> Supported Living |
| <input type="checkbox"/> Other | | |

Outpatient Counseling Services:

- | | | |
|--|--|---|
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Alcohol/Drug | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Learning Disorder |
| <input type="checkbox"/> Marriage/Family | <input type="checkbox"/> Mental Health (schizophrenia, manic, depression, anxiety, personality, paranoia, post-traumatic stress) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Rape Counseling | <input type="checkbox"/> Sexual Offender Treatment |

Day Programs:

- | | | |
|--|---|--|
| <input type="checkbox"/> Adult Daycare | <input type="checkbox"/> Child Daycare | <input type="checkbox"/> Day Treatment |
| <input type="checkbox"/> Headstart/Preschool | <input type="checkbox"/> Sheltered Workshop | <input type="checkbox"/> Other |

Other:

- | | | |
|---|---|---|
| <input type="checkbox"/> Adoption Services | <input type="checkbox"/> Big Brothers/Big Sisters/Mentoring | <input type="checkbox"/> Boys and Girls Clubs |
| <input type="checkbox"/> Buprenorphine | <input type="checkbox"/> Case Management | <input type="checkbox"/> Child Welfare |
| <input type="checkbox"/> Community Action | <input type="checkbox"/> Community Services | <input type="checkbox"/> Electroshock Therapy |
| <input type="checkbox"/> Employee Assistance | <input type="checkbox"/> Equine Therapy | <input type="checkbox"/> Foster Care Case Mgmt |
| <input type="checkbox"/> Home Health-Professional | <input type="checkbox"/> Home Health- Non-Professional | <input type="checkbox"/> Medical/Physical Rehab |
| <input type="checkbox"/> Methadone | <input type="checkbox"/> Physical/Speech/
Occupational Therapy | <input type="checkbox"/> Suboxone |
| <input type="checkbox"/> Suicide Intervention | <input type="checkbox"/> Thrift Store | <input type="checkbox"/> YMCA |
| <input type="checkbox"/> YWCA | | |

III. CURRENT INSURANCE

12. Current Insurance:

Professional Liability

Company: _____

Inception Date: _____ Expiration Date: _____

Premium \$ _____

Deductible \$ _____

Limit of Liability \$ _____

Occurrence Form? _____ or Claims Made? _____

If Claims Made form, Retroactive Date: _____

General Liability

Company: _____

Inception Date: _____ Expiration Date: _____

Premium \$ _____

Deductible \$ _____

Limit of Liability \$ _____

Occurrence Form? _____ or Claims Made? _____

If Claims Made form, Retroactive Date: _____

13. Limits Requested: Professional Liability \$ _____ General Liability \$ _____

IV. LOSS INFORMATION

14. Has any proposed Insured ever had any insurance company cancel, rescind, or non-renew any insurance? Yes No

If yes, explain: (Not applicable to Missouri applicants.)

15. Have there been any claims or lawsuits in the last five years? Yes No

If yes, provide the following:

Date of Loss	Amount Paid or Reserved	Claimant's Name/Description of Claim (Attach separate sheet if necessary)

16. Are you aware of any fact, circumstance, or situation (even if you believe the claim or lawsuit would be without merit) which might give rise to a claim or lawsuit that has not been reported to your current or prior carrier? Yes No

If yes, explain:

17. Within the past 5 years have there been, or are there currently pending, any of the following that have not been reported to your insurer? Yes No

If yes, check all that apply and provide details:

- Arbitrations
 Mediations
 Litigations
 Dismissals
 Settlements
 Proceedings, investigations, or audits instituted against you
 A letter or request from an interested party (including a request for records) regarding the treatment of a client

18. Has any proposed insured been the subject of a disciplinary investigation or proceeding, or reprimanded by any governmental or administrative agency, hospital or professional association? Yes No

If yes, provide details:

19. Within the last 5 years has a federal, state, county, city, and/ or municipal agency taken any of the following actions with respect to a proposed Insured's license or accreditation? Yes No

If yes, explain below:

- Suspended: _____
- Denied: _____
- Revoked: _____
- Placed under probationary status: _____
- Placed under conditional status: _____

20. Attach the most recent accrediting agency (JCAHO, CAREF, etc.) and state license report, including **any** recommendations and responses to any contingencies, for each and every licensed and/or accredited facility.

It is understood that, with respect to Questions 15, 16, 17, 18 & 19, any claim or action arising out of such facts, circumstances or situations is excluded from the proposed coverage.

V. STAFF

21. Schedule of Staff:

	Employed		Contracted		Volunteers
	Full-Time	Part-Time	Full-Time	Part-Time	
Administrators					
Behavioral Health Nurse Practitioners					
Behavioral Health Physician Assistants					
Case Managers					
Clerical					
Counselors					
Homemakers/Aides					
Nurses (LPN)					
Nurses (RN)					
Psychologists					
Social Workers					
Students					
Other, please specify					

22. Schedule of Physician Staff (employed, contracted or volunteer): Check if None

Name	Specialty	Hours Worked Weekly	Employed (E) Contracted (C) Volunteer (V)	Carries own malpractice? (Y/N)	Is physician covered while working for proposed Insured? (Y/N)

23. Do you wish physicians to be covered under your center's policy? Yes No
(Not applicable to Pennsylvania applicants)

24. Do you require your physicians to carry their own insurance? Yes No
If yes, do you assume the cost for his/her individual insurance? Yes No

25. Are drugs or medications administered? Yes No

If yes, who administers? _____

How are drugs or medications stored and secured? _____

26. Are drugs or medications prescribed? Yes No

If yes, are medications prescribed by client's physician or Insured physician? _____

VI. PRIMARY MEDICAL CARE

(Primary medical care means any medical care of any type except for the evaluation, diagnosis, and treatment of any mental illness, substance abuse, or behavioral health of your patients.)

27. Are you currently providing primary medical care? Yes No

28. Do you currently contract or partner with a primary medical care provider to provide services for your organization? Yes No

29. If you are not currently providing primary medical care, do you anticipate providing it or contracting/partner for it within the next year? Yes No

30. Are you a Federally Qualified Health Center (FQHC)? Yes No

(If you answered YES to questions 27, 28, 29 or 30, please complete the Primary Medical Care Supplemental Application for coverage to be considered.)

VII. CONTRACTUAL AGREEMENTS

31. Does the proposed Insured's legal counsel review all contractual agreements? Yes No

32. Does the proposed Insured consult legal counsel with regards to contractual requirements involving primary and non-contributory language and waiver of subrogation requests? Yes No

33. Schedule of Additional Insureds: Check if None

Name and Address (including ZIP)	Interest
	<input type="checkbox"/> Funding Source <input type="checkbox"/> Contract Holder <input type="checkbox"/> Landlord <input type="checkbox"/> Other
	<input type="checkbox"/> Funding Source <input type="checkbox"/> Contract Holder <input type="checkbox"/> Landlord <input type="checkbox"/> Other
	<input type="checkbox"/> Funding Source <input type="checkbox"/> Contract Holder <input type="checkbox"/> Landlord <input type="checkbox"/> Other

VIII. EXPOSURE UNITS

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

Loc. #	Complete Address (including ZIP)	Sq. Feet	Type of Services Provided

35. Units of Service:

Residential Beds/Units (Licensed Capacity)

Alcohol/Drug Inpatient	_____	Alcohol/Drug Social Detox	_____	Alcohol/Drug Medical Detox	_____
Apartments	_____	Battered Family	_____	Criminal Offenders	_____
Crisis beds	_____	Developmentally Disabled	_____	Domestic Violence	_____
Eating Disorder	_____	Foster Care	_____	Group Home	_____
Halfway House	_____	HIV/AIDS	_____	Hospice	_____
Independent Living	_____	Juvenile Residential	_____	Lockdown Facilities	_____
Mental Health Inpatient	_____	Psychiatric	_____	Senior/Adult Home	_____
Sexual Offender Treatment	_____	Shelters	_____	Supported Living	_____
Other	_____				

Outpatient Counseling (Annual Visits or Contacts)

Adoption	_____	Alcohol/Drug	_____	Attention Deficit Disorder	_____
Domestic Violence	_____	Eating Disorder	_____	HIV/AIDS	_____
Home Health -Non Professional	_____	Home Health -Professional	_____	IV Therapy	_____
Marriage/Family	_____	Mental Health	_____	Pregnancy/Rape	_____
Sexual Offender Treatment	_____	Other	_____		

Clients (Per Day Unless Otherwise Indicated)

Adoption -Domestic (Annually)	_____	Adoption-Int'l (Annually)	_____	Adult Daycare	_____
Case Mgmt.-Foster Care	_____	Case Management-Other	_____	Child Daycare	_____
Child Welfare	_____	Day Treatment	_____	Headstart/Preschool	_____
Mentoring	_____	Sheltered Workshop	_____	Vocational	_____
Other	_____				

Other: (Annual Contacts Unless Otherwise Indicated)

Buprenorphine (# of clients)	_____	Electroshock	_____	Employee Assistance (EA)	_____
				# of EA Contracts	_____
Hotline calls	_____	Information/Referrals	_____	Methadone Dosages	_____
Occupational Therapy	_____	Physical Therapy	_____	Speech Therapy	_____
Suboxone (# of clients)	_____	Suicide Intervention	_____	Other	_____

36. Indicate if the proposed insured provides any of the following:

- Camps: (describe) _____
- Adventure/Wilderness Program: (describe) _____
- Ropes Course: High Low
- Swimming:
 - On-premises Off-premises Other _____
 - Pool Lake
- Boating: (describe) _____

37. Describe any other operations, programs, services or activities that are not included in your website or submitted brochure:

Attach a supplemental application for Residential or Inpatient, Day Care/Pre-School/Headstart, Methadone/Buprenorphine, Foster Care/Adoption, Sheltered Workshop/Vocational Services, Primary Medical Care if applicable.

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: _____ TITLE: _____

(Must be signed by Executive Director, President, CEO, CFO or Chairperson of the Board)

DATE: _____

(Please print or type name)

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 part of this policy.

NOTICE

1.THE INSURANCE POLICY THAT YOU [HAVE PURCHASED] [ARE APPLYING TO PURCHASE] IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NON-ADMITTED” OR “SURPLUS LINE” INSURERS.

2.THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.

3.THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

4.THE INSURER SHOULD BE LICENSED EITHER AS A FOREIGN INSURER IN ANOTHER STATE IN THE UNITED STATES OR AS A NON-UNITED STATES (ALIEN) INSURER. YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357. ASK WHETHER OR NOT THE INSURER IS LICENSED AS A FOREIGN OR NON-UNITED STATES (ALIEN) INSURER AND FOR ADDITIONAL INFORMATION ABOUT THE INSURER. YOU MAY ALSO CONTACT THE NAIC’S INTERNET WEB SITE AT WWW.NAIC.ORG.

5.FOREIGN INSURERS SHOULD BE LICENSED BY A STATE IN THE UNITED STATES AND YOU MAY CONTACT THAT STATE’S DEPARTMENT OF INSURANCE TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.

6.FOR NON-UNITED STATES (ALIEN) INSURERS, THE INSURER SHOULD BE LICENSED BY A COUNTRY OUTSIDE OF THE UNITED STATES AND SHOULD BE ON THE NAIC'S INTERNATIONAL INSURERS DEPARTMENT (IID) LISTING OF APPROVED NONADMITTED NON-UNITED STATES INSUREERS. ASK YOUR AGENT, BROKER, OR "SURPLUS LINE" BROKER TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.

7.CALIFORNIA MAINTAINS A LIST OF APPROVED SURPLUS LINE INSURERS. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEBSITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: WWW.INSURANCE.CA.GOV.

8.IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.

Date: _____
Insured: _____

D-1 (Effective July 21,2011)