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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:

❑ 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
❑ Homeless Shelters
❑ Hospice
❑ Independent Living
❑ Juvenile Residential
❑ Lockdown Facilities
❑ Mental Health Inpatient
❑ Psychiatric
❑ Senior/Adult Home
❑ Sexual Offender Treatment
❑ Supported Living
❑ Other

Outpatient Counseling Services:

❑ Adoption
❑ Alcohol/Drug
❑ Attention Deficit Disorder
❑ Eating Disorder
❑ HIV/AIDS
❑ Learning Disorder
❑ Marriage/Family
❑ Mental Health (schizophrenia, manic, depression, anxiety, personality, paranoia, post-traumatic stress)
❑ Other
❑ Pregnancy
❑ Rape Counseling
❑ Sexual Offender Treatment

Day Programs:

❑ Adult Daycare
❑ Child Daycare
❑ Day Treatment
❑ Headstart/Preschool
❑ Sheltered Workshop
❑ Other

Other:

❑ Adoption Services
❑ Big Brothers/Big Sisters/Mentoring
❑ Boys and Girls Clubs
❑ Buprenorphine
❑ Case Management
❑ Child Welfare
❑ Community Action
❑ Community Services
❑ Electroshock Therapy
❑ Employee Assistance
❑ Equine Therapy
❑ Foster Care Case Mgmt
❑ Home Health-Professional
❑ Home Health- Non-Professional
❑ Medical/Physical Rehab
❑ Methadone
❑ Physical/Speech/ Occupational Therapy
❑ Suboxone
❑ Suicide Intervention
❑ Thrift Store
❑ YMCA
❑ 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, CARF, 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
	❑ Funding Source ❑ Contract Holder ❑ Landlord ❑ Other
	❑ Funding Source ❑ Contract Holder ❑ Landlord ❑ Other
	❑ Funding Source ❑ Contract Holder ❑ Landlord ❑ 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 Indictaed)

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.

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.

This insurance contract is with an insurer not licensed to transact insurance in this state and is issued and delivered as a surplus line coverage under the Texas insurance statues. The Texas Department of Insurance does not audit the finances or review the solvency of the surplus lines insurer providing this coverage, and this insurer is not a member of the property and casualty insurance guaranty association created under Article 21.28-C, Insurance Code. Section 12, Article 1.14-2, Insurance Code, requires payment of 4.85 percent tax on gross premium.

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.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____

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

PRODUCER'S SIGNATURE: _____ DATE: _____

AGENT NAME: _____ AGENT LICENSE NUMBER: _____

(Applicable to Florida Agents Only)

IOWA LICENSED AGENT: _____

PRODUCER'S SIGNATURE: _____ DATE: _____

(Applicable to New Hampshire Producers Only)

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.