



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:

- | | |
|--|---|
| <input type="checkbox"/> Adoption Agency * | <input type="checkbox"/> Meals on Wheels |
| <input type="checkbox"/> Child Day Care * | <input type="checkbox"/> Nanny Services |
| <input type="checkbox"/> Day Care (Senior Citizens) * | <input type="checkbox"/> Employee Assistance Program |
| <input type="checkbox"/> Day Care (Senior Citizens) * | <input type="checkbox"/> Referral Agency * (Consultants Supplement) |
| <input type="checkbox"/> Foster Care * | <input type="checkbox"/> Sheltered Workshop * |
| <input type="checkbox"/> Hotlines (Phone Crisis Service) | <input type="checkbox"/> 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)

<u>E</u>	<u>C</u>		<u>E</u>	<u>C</u>	
—	—	Dietitians/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 DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant/Title