PROFESSIONAL LIABILITY APPLICATION
for
MENTAL HEALTH COUNSELING SERVICES / CLINICS

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED.
If the answer is NONE, state NONE;
If the answer 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 (including dba's): ______________________________
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 Year entity established: ______________________________
1.8 The Applicant is (Please check and complete A) of B) below:
______ A. The **APPLICANT** is an INDIVIDUAL. If so, the INDIVIDUAL is an:
__ Employee (W-2) __ Student __ Ind. Contr. (1099) __ Sole Practitioner
______ B. The **APPLICANT** is a:
__ Sole Proprietorship __ Partnership __ Corporation
__ Other - Describe:______________________________
1.9 Entity is _____ For Profit ______ Non-Profit, Describe source of funds: ____________________
1.10 Proposed Effective Date: ______________________________
1.11 Requested Limits of Liability (if available): $ ____________________/$ ____________________
Is General Liability coverage also desired? _____ No _____ Yes
1.12 Annual Gross Receipts: Estimated next twelve months - $____________________
Last twelve months - $____________________
1.13 Number of Patient Encounters: Next 12 months: ______________ Last 12 months ______________
1.14 Premises Square Footage Area occupied by applicant: __________ Are any off premises services provided? If yes, describe:______________________________
____

PART II. EXPOSURES

2.1 Service is licensed as ______________________________

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted: _
____
____

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

2.4 (a) Does applicant conduct group therapy sessions which exceed four (4) hours in duration, or more than 25 patients/clients any one occasion? ____ No ___ Yes IF YES, give frequency and length of sessions, and # patients/clients: ______________________________(b) Does applicant conduct any seminars, workshops or other "group activities" away from regular office premises (including teaching seminars for fellow professionals) ____ No ____ Yes IF YES, give frequency of seminars and # participants/attendees. ____________________

2.5 Does applicant sell, rent or otherwise distribute any products (including any records, audio tapes, video tapes, films, etc.) ___ No ___ Yes IF YES, describe and give est. receipts.

2.6 Does applicant utilize any of the following modalities in the treatment of more than 50% of applicant's patients/clients.

A)	Hypno Therapy	___ No	___ Yes	If yes, ___%
B)	Biofeedback	___ No	___ Yes	If yes, ___%
C)	Kinesthetics	___ No	___ Yes	If yes, ___%
D)	Psychodrama	___ No	___ Yes	If yes, ___%
E)	Bioenergetics	___ No	___ Yes	If yes, ___%

2.7 Does applicant routinely (more than twice in last three years) provide testimony in:

1) Child custody hearing	___ No	___ Yes	If Yes, # times 3 yrs ______
2) Competency hearings	___ No	___ Yes	If Yes, # times 3 yrs ______
3) As an expert witness in criminal or civil trials or other legal proceeding	___ No	___ Yes	If Yes, # times 3 yrs ______

2.8 Does applicant assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying or apprehending criminal offenders? ___ No ___ Yes
IF YES, describe and give frequency ____________________

2.9 Does applicant's practice involve the following: **If Yes, give % of practice**, by income, hours or # clients.

Child/pediatric therapy	___ No	___ Yes	If yes, ____%
Criminal offender therapy/evaluation	___ No	___ Yes	If yes, ____%
Therapy for victims of criminal sexual abuse	___ No	___ Yes	If yes, ____%
Therapy for substance abusers	___ No	___ Yes	If yes, ____%
Crisis Intervention	___ No	___ Yes	If yes, ____%
Therapy for sexual response/disfunction	___ No	___ Yes	If Yes, ____%

2.10 Does applicant's practice involve the following: If YES, give % of practice, and number of clients treated in the last three years. Diagnosis / treatment of:

"Failed/Repressed" Memory Syndrome	___ No	___ Yes	If Yes, ____%	_______ # clients 3 yrs
Multiple Personality Disorder	___ No	___ Yes	If Yes, ____%	_______ # clients 3 yrs

2.11 Are any of applicant's patients/clients referred (or remanded) by courts of law or attorneys or other legal representatives of the patient/client? ____ No ____ Yes IF YES, give % of patients.______________

2.12 **Unless otherwise noted hereunder**, the following are true statements with regard to the applicant:

a) Applicant, including employees and independent contractor, is not a principal with any healthcare related partnership, association or corporation, nor is applicant a proprietor, superintendent, officer, director, stockholder or member of the board of directors, trustees, or governors of any healthcare related business enterprise;

b) Applicant does not provide billing or collection services for any other professional person or organization;

c) Applicant does not share staff with any other professional person or organization;
d) Applicant does not share office premises with any psychiatrist or any other physician;
e) Applicant, including employees and independent contractors, is not licensed or authorized to provide any other professional services except as stated in application;
f) Applicant, including employees and independent contractors, has never had his/her license or certification revoked or suspended, not been the subject of any disciplinary proceeding, not been reprimanded by an administrative agency, professional association or peer committee;
g) Applicant, including employees and independent contractors has never had a claim or suit brought against him/her because of any alleged malpractice, error or mistake arising out of his/her professional services, and applicant is not aware of any circumstances which might result in such a claim or suit.

EXCEPTIONS, if any, to above (absence of entry means "no exceptions"):______________________

____

____

PART III. RISK MANAGEMENT

3.1 Please list all professional staff including degrees held, professional designation:
a) Salaried Employees (W-2) ____

____

b) Independent Contractors (1099) ____

____

c) Interns (W-2 or 1099) ____

____

d) Professional Associates Sharing Premises ___________________________________

____

3.2 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf?
___ No ___ Yes
If no, do you require contracted staff (if any) to carry their own Professional Liability Insurance?
___ No
Yes
Do you secure Certificates of Insurance as evidence of such coverage? ___ No
Yes

3.3 List all memberships in professional organizations. ______________________________

____

3.4 Do you enter into contractual agreements to provide professional services? ___ No ___ Yes
IF YES, enclose copies of all such contracts.
Do you provide services under contract, with said services billed by the other party in lieu of you billing direct for your services? ____ No ____ Yes If Yes, identify contract and services provided:

____

____

____

3.5 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? ___ No ___ Yes
If not, are you agreeable to instituting this procedure? ___ No ___ Yes

ENCLOSE COPY OF YOUR LETTERHEAD, BROCHURES, ADVERTISING.

PART IV. HISTORY

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

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

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

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

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

If claims-made, 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?
___ No ___ Yes 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?
___ No ___ Yes 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 applicant has not withheld 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

DRUG AND SUBSTANCE ABUSE TESTING
SUPPLEMENTAL QUESTIONNAIRE

1. Type specimens taken / tested:

_______ Urine _______ Blood

______ Other: Describe ____

2. Who does testing?

_______ Insured's own laboratory / staff

_______ Laboratory insured contracts with for this service (include copy of contract and confirmation that lab carries own insurance and at what limits, provide example of letterhead results are sent out on)

_______ Independent Laboratories chosen by others (describe who selects lab facility, include copy of any contracts between the parties, confirm lab's own insurance and limits, and confirm letterhead results sent out on)

3. Describe exactly who reads and interprets the test results:

____

4. Describe the "protocols" in place to prevent reporting of "false positive" results:

____

5. Describe the "policy" regarding "confidentially" of reports and records.

____

6. In the past year:
   (a) How many positive test results? ______
   (b) How many employees:
      (1) treated? _____
      (2) counseled? _____
      (3) terminated from employment? _____

7. Is portable equipment used in any on-site testing operations? Describe fully the equipment including its exact use, who manufactures, any lease involving use of same, include brochure if available.

____

8. Enclose copies of contracts between Insured and Client companies.

ADDENDUM TO MENTAL HEALTH PRACTITIONER'S APPLICATION

SUPERVISION OF OTHERS

Named Insured: ____

Fully describe the scope of your responsibilities as a ***supervisor***, including the percentage of your time spent in this capacity.

Please provide the following information for each individual supervised:

NAME	POSITION	HOURS PER WEEK	COMPENSATED (Yes/No)	INSURED* (Yes/No)	# CONTACTS/WK

How are supervisee's hours billed to the client/patient?	
How does supervisee's patient profile differ from yours?	
Explain circumstances if supervisee is seeing patients away from your workplace.	

* If insured, attach certificate of insurance.