

- 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 estimated 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/dysfunction | 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:
- 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;
 - Applicant does not provide billing or collection services for any other professional person or organization;
 - Applicant does not share staff with any other professional person or organization;
 - Applicant does not share office premises with any psychiatrist or any other physician;
 - 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 List all memberships in professional organizations.

3.3 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:

3.4 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

3.5 **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	Policy Number	Limits of Liability	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	Policy Number	Limits of Liability	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

Supplemental information:

(please reference any questions you are referring to)