

# AGOSTINI

## WHOLESALE INSURANCE

(800) 922-7283 WWW.AGOSTINISURPLUS.COM

# SOCIAL SERVICES PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE

1. Name of Applicant: \_\_\_\_\_
2. Physical Address: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
**(If multiple names and locations, please attach list)**
3. a) Date Established \_\_\_\_\_ Corporation  Partnership  Professional Assoc.  Individual   
b) In what states is the Applicant registered and licensed to practice? \_\_\_\_\_  
\_\_\_\_\_
4. Is the firm engaged in, owned by, associated with or controlled by any other business?  Yes  No  
If Yes, give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Professional Activities and Specialty (Attach narrative description if necessary). Check One:  

_____ Alcohol/Drug Rehabilitation	_____ Mental Health
_____ Day Care	_____ Methadone Treatment
_____ Day School (Mental Health/Retardation)	_____ Physical/Developmental Disability Facility
_____ Family Planning/Crisis Pregnancy	_____ Psychiatry
_____ Foster Care/Adoption Agency	_____ Respite Care
_____ Group Home	_____ Shelter
_____ Hotlines (Phone Crisis Center)	_____ Sheltered Workshop
_____ Meals on Wheels	_____ Social Services
_____ Mental Health Facility	_____ Transitional Living
	_____ Other (Specify): _____
6. State approximate division of Applicant's clients among:  

a) Alcoholics	(     ) %	e) Minors under age 18	(     ) %
b) Counseling/Family Planning	(     ) %	f) Psychiatric	(     ) %
c) Drug Addicts	(     ) %	g) Senile or Aged	(     ) %
d) Mentally Retarded	(     ) %		

7. a. List the number and type of Applicant's employees and volunteers: If None, state None. \_\_\_\_\_

Number	Type of Profession		
i) _____	Analyst	vi) _____	Psychiatrist
ii) _____	Counselor/Therapist	vii) _____	Physiotherapist
iii) _____	Psychoanalyst	viii) _____	Social Worker
iv) _____	Psychologist	ix) _____	Other: _____
v) _____	Psychotherapist		

b. Does the psychiatrist(s) above maintain their own insurance?  Yes  No  
If Yes, for what limits? \_\_\_\_\_

c. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use separate sheet, if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If None, state None. \_\_\_\_\_

d. Are all of the individuals listed in question 7.a. and 7.b. licensed in accordance with applicable state and federal regulations? If No, attach explanation.  Yes  No

**(Attach detailed explanation for any "Yes" answers to the following:)**

e. Has the Applicant or any of the individuals listed in question 7.a. and 7.b.:

- i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?  Yes  No
- ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No
- iii) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?  Yes  No

8. Please provide the following information:

- a. Number of Licensed Beds: \_\_\_\_\_
- b. Number of Occupied Beds: \_\_\_\_\_
- c. Number of Occupied Beds for Detox: \_\_\_\_\_
- d. How many meals are served/delivered annually? \_\_\_\_\_
- e. For Sheltered Workshop/Day School or Adult Day Care:  
Number of participants: \_\_\_\_\_
- f. For Adoption Agency/Foster Care:  
Number of placements: \_\_\_\_\_  
Number of placements with parents: \_\_\_\_\_
- g. For Hotline/Phone Crisis Center:  
Number of calls annually: \_\_\_\_\_

**(Attach detailed explanation for any "Yes" answers to the following:)**

9. Does the Applicant provide any medical treatment?  Yes  No  
 If Yes, please provide details.

10. State sources and amounts of total revenue:

Source	Amount Last Policy Year Est.	Amount This Policy Year
A. Charitable Contributions	\$ _____	\$ _____
B. Government Funding	\$ _____	\$ _____
C. Fee for Services	\$ _____	\$ _____
D. Other: _____	\$ _____	\$ _____
E. Other: _____	\$ _____	\$ _____
<b>TOTAL GROSS REVENUE</b>	<b>\$ _____</b>	<b>\$ _____</b>

11. Number of estimated client/patient encounters last 12 months: \_\_\_\_\_  
 (Note: "client/patient encounters" refers to number of visits – not number of client/patients)

12. Number of estimated client/patient encounters and client/patient services or tests in the next 12 months:

Client/Patient encounters: \_\_\_\_\_

13. Describe Professional Liability coverage for the last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If the expiring policy is claims made, what is the retroactive date? \_\_\_\_\_

14. Has any insurer cancelled or refused to renew any similar insurance during the past five years?  Yes  No

If Yes, please describe: \_\_\_\_\_

15. Is the Applicant currently insured under a Commercial General Liability Policy?  Yes  No  
 If Yes, please give details:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If the expiring policy is claims made, what is the retroactive date? \_\_\_\_\_

16. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?  Yes  No  
If Yes, please give details: \_\_\_\_\_

17. Has any claim ever been made against the firm or any of its employees?  Yes  No  
If Yes, please submit currently valued carrier loss runs for the past 5 years and attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

18. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?  Yes  No  
If Yes, please give full details on the same basis as item 17.

19. Limits of Liability requested \_\_\_\_\_ Deductible \_\_\_\_\_

20. Desired term of policy: From \_\_\_\_\_ To \_\_\_\_\_

**The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.**

**It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.**

**It is agreed that in the event there is any material change in the answers to the questions contained herein proper to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.**

**For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.**

**For Kentucky residents:**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.**

Name of Applicant: \_\_\_\_\_  
Please Print Title

Signature: \_\_\_\_\_  
Name Date