

# Social Services Professional Liability Application for Mental Health/Family Counseling Services



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

Tax ID/SSN: \_\_\_\_\_

1.1 Applicant Name (including DBAs): \_\_\_\_\_

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 or B below):

A. The **applicant** is an individual. If so, the individual is a(n):  
 Employee (W-2)  Student  Ind. Contr. (1099)  Sole Practitioner

B. The **applicant** is a(n):  
 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 12 Months: \$ \_\_\_\_\_  
 Last 12 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 # of 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 | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| b) Biofeedback   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| c) Kinesthetics  | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| d) Psychodrama   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| e) Bioenergetics | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
- 2.7 Does applicant routinely (more than twice in last three years) provide testimony in:
- |  |  |                              |
|--|--|------------------------------|
| a) Child Custody Hearing   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, # times 3 yrs _____  |
| b) Competency Hearings   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, # times 3 yrs _____  |
| c) As an expert witness in criminal or civil trials or other legal proceeding? | <input type="checkbox"/> No <input type="checkbox"/> 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 # of clients.
- |  |  |                |
|--|--|----------------|
| Child/pediatric Therapy                      | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| Criminal Offender Therapy/evaluation         | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| Therapy for Victims of Criminal Sexual Abuse | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| Therapy for Substance Abusers                | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| Crisis Intervention                          | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% |
| Therapy for Sexual Response/dysfunction      | <input type="checkbox"/> No <input type="checkbox"/> 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 | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, _____% | _____ # clients 3 yrs |
| Multiple Personality Disorder      | <input type="checkbox"/> No <input type="checkbox"/> 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 health care-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 health care-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 that 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 and 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) that 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, and advertising.**

**Part IV. History**

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

	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, state none.

	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 ProAssurance Mid-Continent Underwriters, 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

**Mental Health Practitioners Exceptions Supplement  
(Individual Coverage)**

Unless otherwise noted hereunder, the following are true statements applicable to the **insured**:

- a) **Insured** does not conduct group therapy sessions which exceed four (4) hours in duration;
- b) **Insured** does not conduct any seminars, workshops, or other "group activities" away from his/her regular office premises that involve more than twenty-five (25) patients/clients in any one occasion;
- c) **Insured** does not sell, rent, or otherwise distribute any products (including but not limited to any records, audio tapes, videotapes, films);
- d) Not more than twenty-five percent (25%) of the **insured's** practice (by income, hours, or # of clients) involves: i) criminal or sex abuse offender therapy or evaluation, or ii) therapy for victims of sex abuse;
- e) **Insured** does not routinely (more than five in last three years) provide testimony i) in child custody hearings, ii) in competency hearings, iii) as an expert witness in legal proceedings;
- f) **Insured** does not assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying, or apprehending criminal offenders;
- g) Not more than fifty percent (50%) of **insured's** practice (by income, hours of service, or number of patients/clients) involves the following: i) child/pediatric therapy, ii) therapy for substance abusers, iii) crisis intervention, iv) therapy for sexual response/dysfunction; or the following modalities in treatment, v) hypnotherapy, vi) biofeedback, vii) kinesthetics, viii) psychodrama, or ix) bioenergetics;
- h) **Insured's** practice does not involve treatment for dissociative disorder not otherwise specified, commonly referred to as "false memories disorder" or "repressed memory disorder;"
- i) **Insured's** practice does not involve treatment for dissociative identity disorder (multiple personality disorder);
- j) Not more than twenty-five percent (25%) of **insured's** patients/clients are referred (or remanded) by courts of law or attorneys or other legal representatives of the patient/client;
- k) **Insured** does not provide billing or collection services for any other professional person or organization;
- l) **Insured** does not share office premises with any psychiatrist or any other physician;
- m) **Insured** is not licensed or authorized to provide any other professional services;
- n) **Insured** has never had his/her license or certification revoked or suspended, nor been the subject of any disciplinary proceeding, nor been reprimanded by any administrative agency, professional association, or peer committee;
- o) **Insured** 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 **insured** is *not* aware of any circumstances that might result in such a **claim** or **suit**.

**Exceptions**, if any, to above (absence of entry means "no exceptions"): \_\_\_\_\_

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# Physician's Exposures Supplement



**Instructions:** Complete this supplement in its entirety. If a specific item is not applicable, state N/A. If the space provided is insufficient to complete the item, attach a separate sheet. Please note this supplement is part of the application and all warranties and statements contained therein apply to this supplement.

Tax ID/SSN: \_\_\_\_\_

**P.1.1 Credentialing**

Is there a written policy and procedure for credentialing of physicians, surgeons, and dentists who provide professional services at your entity?  Yes  No  
If yes, attach a copy of the policy and procedure. If no, describe in detail your entity's credentialing process.

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**P.1.2 Insurance Verification\***

Does your entity require proof of insurance of physicians, surgeons, and dentists?  Yes  No  
If yes, does the entity determine the type of coverage (occurrence or claims-made)?  Yes  No  
If yes, does the entity require those with claims-made coverage to purchase the "tail" if the policy is cancelled?  Yes  No

**P.1.3 Physician Listing**

List by individual profession, each physician, surgeon, and dentist who provides professional services at your entity on the second sheet of this supplement. Include *all* types (employed, contract, and staff). Indicate limit of professional liability carried by each.

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**P.1.4 Additional Staffing**

Does the entity anticipate employing or contracting with any additional physicians, surgeons, or dentists during the next 12 months?  Yes  No  
If yes, please indicate approximate number(s) and specialty(ies): \_\_\_\_\_

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**P.1.5 Large Claim**

Has any of the entity's physician staff had a claim or suit where the indemnity payment or reserve was greater than \$10,000?  Yes  No

# Sexual Misconduct Coverage Supplemental Application



Tax ID/SSN: \_\_\_\_\_

1. Applicant: \_\_\_\_\_

2. Has the applicant had any incidents or claims reported for sexual misconduct or any other allegation of abuse?  
If yes, provide full details:  Yes  No

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

3. Has the applicant or any employee, volunteer, or other person working for the applicant ever been arrested or convicted of a crime? If yes, provide full details:  Yes  No

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

4. Describe all background checks performed: \_\_\_\_\_

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

5. Are there written guidelines regarding sexual misconduct? If yes, provide copies of all policies and procedures including training materials.  Yes  No

6. What steps have been taken to prevent or avoid a sexual misconduct incident? \_\_\_\_\_

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

Date: \_\_\_\_\_

Signature: \_\_\_\_\_



# Non-Owned Auto Supplemental Application



**If non-owned auto coverage is desired, please complete the following:**

**Note:** Non-owned coverage is written only as an endorsement to the General Liability policy, does not include Hired Car, and shares the limits, deductibles and other conditions of the general liability policy. This coverage is not intended to cover livery operations by the insured, whether a fee is charged or not, and therefore excludes bodily injury to passengers of any insured non-owned autos.

Tax ID/SSN: \_\_\_\_\_

1. How many employees drive their personal auto in connection with your business: \_\_\_\_\_  
 How many of these are part-time employees? 15-25 hrs wk \_\_\_\_\_ Under 15 hrs wk \_\_\_\_\_

If persons other than employees use their personal auto in connection with your business, please describe and give number: \_\_\_\_\_

None \_\_\_\_\_

2. What are the ages of the drivers?  18-25  25-35  35-45  45-5  55-65  Over 65

3. Does applicant check all driver's MVRs? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Does applicant require minimum limits of at least 100/300 BI - 50 PD? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Please attach evidence of each driver's auto insurance showing the limits carried.

5. Does applicant require employees or others to provide transportation for patients/clients in their personal auto? Yes \_\_\_\_\_ No \_\_\_\_\_

6. Does applicant have owned, leased, or hired autos used in business? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Insurance coverage: Carrier: \_\_\_\_\_  
 Limit: \_\_\_\_\_ Effective Date: \_\_\_\_\_

7. Have any auto claims been made or occurrences reported during the past five years? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, describe, indicate open/closed status, and amounts paid or reserved:

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

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Applicant/Title