Cyber & Professional Lines Group
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main (818) 382-2030

Social Services Professional Liability and General Liability Insurance Application

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THIS APPLICATION IS NOT A BINDER.

This application for Professional Liability and General Liability Insurance is intended to be used for the preliminary evaluation of a submission. When completed in its entirety, this application will enable the Underwriter to decide whether or not to authorize the binding of insurance. Please type or print clearly and answer all questions. If space is insufficient to answer any question fully, attach a separate sheet. Complete all required supplemental forms/applications. "You" and "Your", as used in this application, means the Applicant.

1. GENERAL INFORMATION			
Name of Applicant			
(If multiple names and locations, please attach list.)			
Street Address		Phone	
City, State, Zip Code		County	
Website		Contact e-mail	

2. FORM OF BUSINESS

a. Applicant is a(an): ☐ Individual ☐ Corporation ☐ Partnership ☐ Professional Association

b. Date established:

c. Where is the Applicant registered and licensed to practice (number of states)?

d. Please list all subsidiaries to which this insurance will apply. Include a complete description of the operations of each subsidiary with confirmation that this Application reflects all exposures **(attach a separate sheet if necessary)**.

e. Is the Applicant engaged in, owned or controlled by, or associated with, any other business? ☐ Yes ☐ No
If "YES", please provide details:

3. COVERAGE DESIRED

a. Proposed Effective Date:	
b. Retroactive Date:	
c. Limit(s):	
d. Deductible(s):	

4. REVENUES (please describe the sources and amount of the Applicant's total revenue)

Source	Amount Last Policy Year (estimated)	Amount this Policy Year
a. Charitable Contributions	$	$
b. Government Funding	$	$
c. Fee for Services	$	$
d. Other: _____	$	$
e. Other: _____	$	$
f. TOTAL GROSS REVENUE:	$	$

5. PROFESSIONAL ACTIVITIES AND SPECIALTY (attach narrative description, if necessary)

CHECK ONE:

- ☐ Alcohol/Drug Rehabilitation
- ☐ Day Care
- ☐ Day School (Mental Health/Retardation)
- ☐ Family Planning/Crisis Pregnancy
- ☐ Foster Care/Adoption Agency
- ☐ Group Home
- ☐ Hotlines (Phone Crisis Center)
- ☐ Meals on Wheels
- ☐ Mental Health
- ☐ Mental Health Facility
- ☐ Methadone Treatment
- ☐ Physical/Developmental Disability Facility
- ☐ Psychiatry
- ☐ Respite Care
- ☐ Shelter
- ☐ Sheltered Workshop
- ☐ Social Services
- ☐ Transitional Living
- ☐ Other (Please specify): _____

6. CLIENT BREAKDOWN (please state approximate division of the Applicant's clients among the following)

a.	Alcoholics	%	**e.**	Minors under age 18	%
b.	Counseling/Family Planning	%	**f.**	Psychiatric	%
c.	Drug Addicts	%	**g.**	Senile or Ages	%
d.	Intellectually Disabled	%			

7. EMPLOYEES AND VOLUNTEERS

a. List the number of the Applicant's employees and volunteers in each profession below . If None, state "0" by the designated profession.

Type of Profession	Number	Type of Profession	Number
(1) Analyst		(6) Psychiatrist	
(2) Counselor/Therapist		(7) Physiotherapist	
(3) Psychoanalyst		(8) Social Worker	
(4) Psychologists		(9) Other: _____	
(5) Psychotherapists			

b. Do the individuals listed in **7.a.** above maintain their own insurance? ☐ Yes ☐ No

If **"YES"**, what are the limits? _____

c. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use a separate sheet of paper, if necessary. If None, state "None" here: _____

d. Are all of the individuals listed **7.a.** and **7.c.** licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No

If "NO", please attach an explanation.

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

(1) ever been the subject of a disciplinary proceeding, investigation or reprimand by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

(2) ever been convicted of a violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

(3) ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

(4) ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or ever voluntarily surrendered any such license? ☐ Yes ☐ N

If "YES" to any of the above, attach explanation.

8. ADDITIONAL REQUIRED INFORMATION

Please provide the following information:

a. Number of Licensed Beds	
b. Number of Occupied Beds	
c. Number of Occupied Beds for Detox	
d. Number of meals served/delivered annually	
e. For Sheltered Workshop/Day School or Adult Day Care, number of participants	
f. For Adoption Agency/Foster Care:	
i) Number of placements	
ii) Number of placements with parents	
g. For Hotline/Phone Crisis Center, number of calls annually	

h. Does the Applicant provide any medical treatment? ☐ Yes ☐ No
If "YES", please provide details.

i. Number of estimated client/patient encounters in the last 12 months (Note: "client/patient encounters" refers to number of visits; not number of client/patients)	
j. Number of estimated client/patient encounters and client/patient services or tests in the next 12 months:	

9. INSURANCE

a. Please describe the Applicant's Professional Liability coverage for the last five (5) years:

Insurance Carrier	Limit	Deductible	Claims-Made or Occurrence	Premium	Policy Period

If the expiring Professional Liability policy is claims-made, what is the retroactive date? _____

b. Has any insurer cancelled or refused to renew any similar insurance during the past five (5) years? ☐ Yes ☐ No
If "YES", please explain.

c. Is the Applicant currently insured under a Commercial General Liability Policy? ☐ Yes ☐ No
If "YES", please provide details:

Insurance Carrier	Limit	Deductible	Claims-Made or Occurrence	Premium	Policy Period

If the expiring General Liability policy is claims-made, what is the retroactive date? _____

d. Has any application for Professional Liability or General Liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been decline or has the insurance ever been cancelled, non-renewed or accepted only on special terms? **If "YES", please provide details on a separate page.**	☐ Yes ☐ N

10. LOSS HISTORY

If the answer to any question in 10a. through 10.d. below is "Yes", please complete a Claim Supplemental Form for each claim, allegation or incident, and submit a currently valued loss runs for the past five (5) years.

a. In the past five (5) years, has any claim been made, or legal action been brought, against you, any of your current or former officers, directors, owners, partners or employees, or any other person or entity proposed for this insurance?	☐ Yes ☐ No
b. Has the Applicant ever been audited or investigated regarding Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services?	☐ Yes ☐ No
c. Has the Applicant ever been accused of billing errors by any government agency or commercial payer?	☐ Yes ☐ No
d. Are you or any other person or entity proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in any professional liability or general liability claim(s) being made against any person or entity proposed for this insurance?	☐ Yes ☐ No

NOTICE TO APPLICANT

The insurance for which you are applying will not respond to incidents about which any person proposed for coverage had knowledge prior to the effective date of the policy, nor will coverage apply to any claim or circumstance identified or that should have been identified in question 10 of this application.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

The Applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by claim expenses and, in such event, the Insurer shall not be liable for claim expenses or any judgment or settlement that exceed the limit of liability.

I HEREBY DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact, and that I agree that this application shall be the basis of the contract with the Underwriters.

CERTIFICATION AND SIGNATURE

The Applicant has read the foregoing and understands that completion of this application does not bind the Underwriter or the Broker to provide coverage. It is agreed, however, that this application is complete and correct to the best of the Applicant's knowledge and belief, and that all particulars which may have a bearing upon acceptability as a Professional Liability and General Liability Insurance risk have been revealed.

It is understood that this application shall form the basis of the contract should the Underwriter approve coverage and should the Applicant be satisfied with the Underwriter's quotation. It is further agreed that, if in the time between submission of this application and the requested date for coverage to be effective, the Applicant becomes aware of any information which would change the answers furnished in response to any question of this application, such information shall be revealed immediately in writing to the Underwriter.

This application shall be deemed attached to and form a part of the Policy should coverage be bound.

Must be signed by an officer of the company.

Print or Type Applicant's Name	Title of Applicant
Signature of Applicant	Date Signed by Applicant