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

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 ☐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:

a) Child Custody Hearing ☐No ☐Yes If yes, # times 3 yrs _____
b) Competency Hearings ☐No ☐Yes If yes, # times 3 yrs _____
c) 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 # of 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:

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”): _____

_____

_____

_____

_____