JM WILSON
MGA AND E&S BROKER | EST. 1920

Agent Information

Agency Name: _____

Agency Code: _____

Producer/CSR: _____

Phone: _____

Email: _____

New ☐ Renewal ☐

Policy Number: _____

HUNTERSURE LLC

OUTPATIENT MENTAL HEALTH COUNSELING PROFESSIONAL AND GENERAL LIABILITY APPLICATION

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple name and locations, please attach list)

4. Telephone Number: _____ Fax Number: _____

5. a) Date Established: _____

b) Entity Type: Corp. _____ Partnership_____ Prof. Assoc. _____ Individual_____

c) For Profit _____ Non-Profit _____

6. a) Desired Effective Date: _____

b) Desired Limits of Liability: $_____ / $_____

c) Desired Deductible: $_____

7. a) Gross Receipts for Past 12 Months: $_____ b) Est. Gross Receipts for Next 12 Months: $_____

c) Payroll for Past 12 Months: $_____ d) Est. Payroll for Next 12 Months: $_____

e) # of Visits for Past 12 Months: _____ f) Est. # of Visits for Next 12 Months: _____

8. Applicant's Service is licensed as a:_____

9. Full description of services provided:_____

10. Does the applicant have any ancillary operations not stated above? Yes _____ No _____

If yes, please provide details: _____

11. Is the firm engaged in, owned by, associated with or controlled by any other business? If yes, please provide details:

_____

_____

12. Are all services provided at the applicant's location address(s)? Yes _____ No _____

If no, please provide details of any off-site exposure: _____

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13. Describe any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction: _____

14. Please provide a breakdown of the types of counseling services provided & exposures below:

Substance Abuse (Alcohol/Drugs)	_____ %
Ex-Offender Therapy/Evaluation	_____ %
Crisis Intervention	_____ %
Family	_____ %
Marriage	_____ %
General	_____ %
Child/Pediatric	_____ %
Victims of Domestic/Sexual Abuse	_____ %

Other; Describe: _____

15. Does the applicant use hypnotherapy, treat for failed/repressed memory syndrome or use any alternative/non-traditional counseling methods as part of their practice? Yes _____ No _____

If yes, please provide details of methods used & what % this is of their total operation: _____
_____
_____

16. Does the applicant do any of the following:

Provide testimony in child custody hearings? Yes _____ No _____ If yes, # times in past 3 years: _____

Provide testimony in competency hearings? Yes _____ No _____ If yes, # times in past 3 years: _____

Act as an expert witness in criminal/civil trials or other legal proceedings?
Yes _____ No _____ If yes, # times in past 3 years: _____

Treat patients referred/remanded by courts of law or attorneys or other legal representative of the patient?
Yes _____ No _____ If yes, give % of patients: _____

17. a) List the number and type of applicant's employees estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Social Worker	_____	Counselor	_____
Nurse Practitioner	_____	Medical Technician	_____
Physician Assistant	_____	Psychiatrist	_____
Paramedic/EMT	_____	Clerical/Admin	_____
Psychologist	_____	Other (please describe)	_____

b) List the number and type of independent contractors estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Social Worker	_____	Counselor	_____

Nurse Practitioner	_____	Medical Technician	_____
Physician Assistant	_____	Psychiatrist	_____
Paramedic/EMT	_____	Clerical/Admin	_____
Psychologist	_____	Other (please describe)	_____

c. Are all the individuals listed in response to Q17a & b licensed in accordance with applicable state and federal regulations?

Yes _____ No _____ If no, attach explanation.

18. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes _____ No _____ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes _____ No _____

19. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

Yes _____ No _____ If yes, at what limits? $_____ / $_____

20. Does the applicant provide any beds for overnight stays?
If yes, give details: _____

_____

21. Do you sell, rent or otherwise provide any equipment to products or others? If yes, give details including types of products & gross receipts from each: _____

_____

_____

22. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician?

Yes _____ No _____ If no, give details: _____

23. a) Do you conduct pre-employment screening and investigation? Yes _____ No _____

b) Do you question prospects about previous claims or suits? Yes _____ No _____

c) Are employees required to actively participate in continuing education? Yes _____ No _____

d) Do you prepare job descriptions and instructional manuals for your staff? Yes _____ No _____

e) Do you have a written incident/occurrence reporting policy and procedures? Yes _____ No _____

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24. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications	_____	Criminal Background Checks	_____
Drug / HIV/ Hepatitis Testing	_____	Licenses Held	_____
Education/Training/Competence	_____	Multi-State Registry	_____

25. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

_____

_____

26. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	_____	_____
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c) Ever been treated for alcoholism or drug addiction?	_____	_____
d) 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?	_____	_____

27. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes_____ No_____

If yes, give details, including name, location size and number of beds:

_____

28. Do you provide any legal and/or financial services or handle client's money, bills or finances of any type?

Yes _____ No _____

If yes, please provide details: _____

29. Do you act as legal guardian or power of attorney for anyone?

Yes _____ No _____

If yes, please provide details: _____

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30. Give Professional Liability coverage for last five years for the firm:

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

If expiring insurance is a claims made policy, what is the retroactive date? _____

31. Give General Liability coverage for last five years for the firm:

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

If expiring insurance is a claims made policy, what is the retroactive date? _____

32. 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 _____

33. Has any insurer cancelled or refused to renew any similar insurance during the past five years?

Yes_____ No_____ If yes, please give full details.

34. Has any claim ever been made against the firm or any of its employees?

Yes_____ No_____

If yes, please 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.

35. 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.

HUNTERSURE LLC

Application for Claims-Made Professional Liability Insurance

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 that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: 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 act, which is a crime.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)