Professional Liability Application for Social Services With No Residential Exposure

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

PROASSURANCE Treated Fairly

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: _____

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 Proposed **Effective Date**: _____ 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:
☐Sole Proprietorship ☐Partnership ☐Corporation
☐Other; Describe: _____

1.9 Entity is: ☐For Profit ☐Non-Profit

Describe source of funds: _____

1.10 Requested Limits of Liability (if available):

Professional Liability $_____ Each Medical Incident/ $_____ Aggregate
General Liability $_____ Each Occurrence/ $_____ General Aggregate

1.11 Annual Gross Receipts or Budget: Estimated Next 12 Months: $_____
Last 12 Months: $_____

1.12 Annual Payroll or Remuneration: Estimated Next 12 Months: $_____
Last 12 Months: $_____

1.13 Type of Facility: Licensed? ☐Yes ☐No If no, explain:_____

Check One or Describe:

☐Adoption Agency*
☐Child Day Care*
☐Day Care (Senior Citizens)*
☐Foster Care*
☐Hotlines (Phone Crisis Service)
☐Meals on Wheels
☐Nanny Services
☐Employee Assistance Program
☐Referral Agency* (Consultants Supplement)
☐Sheltered Workshop*
☐Other:_____

*Applicable supplemental questionnaire must be completed.

1.14 Describe the nature of insured's operation including types of services rendered and activities conducted:

1.15 List memberships in professional organizations:_____

1.16 Is the applicant/facility and all professional employees licensed in accordance with applicable state and federal laws? ☐Yes ☐No
If no, explain: _____

Part II. Exposures

2.1 Does facility provide **"Day"** services? ☐Yes ☐No
If yes, what is the number of "day patients" (include "independent living" persons):
Maximum # ____ Average #____

2.2 Do you conduct a **Sheltered Workshop**? ☐Yes ☐No
If yes, the application for Sheltered Workshops for Retarded and Developmentally Disabled Persons must be completed.

2.3 Are all patients fully ambulatory (including use of cane or walker)? ☐Yes ☐No
If not, explain:_____

2.4 What was your total number of outpatient/client visits last year?_____ Estimated next year?_____

2.5 Do you conduct group therapy sessions? ☐Yes ☐No
If yes, do any sessions exceed four (4) hours in duration? ☐Yes ☐No
If yes, how many annually? _____

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

2.7 Describe any services specifically concerned with sexual response/dysfunction of individual patients/clients:

2.8 Is there a Registered Nurse on duty? ☐Yes ☐No
If yes, how many shifts per day? _____

2.9 Is any medication prescribed? ☐Yes ☐No
If yes, list names and frequency: _____

Are medications stored in a secure manner? ☐Yes ☐No
If no, explain in detail: _____

2.10 Do you enter into any contractual agreements? ☐Yes ☐No
If yes, enclose copies of all such contracts including those contracts for use with patients/clients.

2.11 Enclose a copy of all brochures or advertising materials distributed by you.

2.12 Are any activities or events for patients/clients conducted or sponsored away from applicants? ☐Yes ☐No
If yes, describe: _____

2.13 Any swimming pools, exercise facilities, or athletic activities? ☐Yes ☐No
If yes, please describe (for pool give information re: pool use rules, lifeguard, fencing, and depth): _____

2.14 Describe any "fundraising" or other special events activities conducted: _____

2.15 Do you have any other premises or operations not stated in this application? ☐Yes ☐No
If yes, enclose complete description/locations of operations and insurance information.

Part III. Risk Management

3.1 Do you require staff to report all incidents (accidents)? ☐Yes ☐No
Are records of such reports kept on file by you? ☐Yes ☐No
If not, explain: _____

3.2 Are precautions taken to prevent patients/clients leaving premises or "wandering" without applicant's knowledge, such as exit alarms, etc.? ☐Yes ☐No
Please describe: _____

3.3 Is there a written emergency evacuation plan? ☐Yes ☐No

3.4 State the frequency of fire drills: _____

3.5 Does the applicant/facility have personnel trained in emergency medical care in the facility during all hours of operation? ☐Yes ☐No
Please describe: _____

3.6 Explain arrangements for medical emergencies (e.g., physician on call, transfer arrangement with hospital, etc.): _____

3.7 Number of **Professional Staff**: (**E = Employed; C = Contract**)

E	C		E	C	
☐	☐	Dieticians/Nutritionists	☐	☐	Physiotherapists/Physical Therapists
☐	☐	Occupational Therapists	☐	☐	Psychologists/Psychotherapists
☐	☐	Pharmacists	☐	☐	Psychiatrists*
☐	☐	Physicians*/Dentists*	☐	☐	Speech Therapists
☐	☐	Nurse Practitioners	☐	☐	RNs/LVNs/LPNs
☐	☐	Physician Assistants	☐	☐	Respiratory Therapists
☐	☐	Social Workers	☐	☐	Case Managers
☐	☐	Marriage/Family Counselors	☐	☐	School Counselors
☐	☐	Teachers	☐	☐	Other: _____

Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, and Physician Assistants:

* Complete Physician Supplement when applicable.

Name	Professional Status	E, C, or I	Maintains Own Malpractice Ins.	Limit of Liability	Cert. of Ins. Obtained
		E = Employee C = Contract I = Independent			

3.8 Do you have any physicians on staff admitting patients or treating patients who have restricted licenses? If yes, explain on separate sheet. ☐Yes ☐No

3.9 Name, qualification, and number of years of experience of the Medical Director, all managers, and supervisors:

Name Title Experience/Training Association Membership

_____

_____

_____

3.10 Does the applicant have written screening and hiring policies and procedures for all prospective employees, independent contractors/consultants, and volunteers? If yes, please provide copies of the procedures, including samples of employment applications. ☐Yes ☐No

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

Part IV. History

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

Insurer Number	Policy Liability	Limits of Premium	Eff. Date	Claims-Made Form No	Claims-Made Form 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, starting 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

Physician's Exposures Supplement

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

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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.

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.

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.

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): _____

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

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1. Applicant: _____

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

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

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

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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.

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

Day Care or Partial Hospitalization Program Supplemental Application

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

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1. Applicant:_____

   Address:_____

   Utilized Square Footage:_____ Describe "exit" alarms/security measures:_____

   Describe any off premises exposures/field trips, etc:_____

   Swimming Pool? ☐ Yes ☐ No Playground Equipment? ☐ Yes ☐ No

   Give details of all pool use rules, depth, lifeguards. Describe playground equipment:_____

   _____

2. Facility's **Licensed # Client Spaces**:_____ Average Occupancy:_____ Hours of Operation:_____

3.

Age Group		**Number of Children**	**Staff/Child Ratio**	**Number of Adult Clients**	
Under 2 Years	_____	_____	_____	18 to 30 Years	_____
2 to 5 Years	_____	_____	_____	31 to 45 Years	_____
6 to 12 years	_____	_____	_____	46 to 65 Years	_____
13 to 18 years	_____	_____	_____	Over 65 Years	_____

4. Give **breakdown** of percentage of **types** of clients serviced:

   Well Child _____% Mentally Retarded _____% Aged _____% Emotionally Disturbed _____%

   Alzheimer/Dementia _____% Alcohol/Drug Rehab _____% Other; Describe: _____/_____%

5. Does **hiring** procedure include: Background/Reference Check? ☐ Yes ☐ No

   Screening for Criminal Record? ☐ Yes ☐ No

   Brief description of hiring procedures:_____

   Staff - Describe credentials, experience, and number of staff:_____

   _____

6. Is **transportation** provided? ☐ Yes ☐ No

   If yes, give a description of vehicles, insurance coverage, and driver screening:_____

   _____

7. What provisions are in place for **medications, injuries or illness**? _____
8. Does applicant carry an **Accident Insurance** policy for clients? ☐ Yes ☐ No If Yes, Limit? _____
9. Describe procedures and precautions for child's release:_____

   _____

10. **Please attach brochure, advertising copy, copies of enrollment form, and parental release forms.**

Date:_____ Signature:_____