

# Professional Liability Application for Social Services With No Residential Exposure

PROASSURANCE  
**MID-CONTINENT**  
UNDERWRITERS, INC



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: \_\_\_\_\_

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: \$ \_\_\_\_\_

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1.13 Type of Facility: Licensed?  Yes  No If no, explain: \_\_\_\_\_

Check One or Describe:

- |  |  |
|--|--|
| <input type="checkbox"/> Adoption Agency*                | <input type="checkbox"/> Meals on Wheels                           |
| <input type="checkbox"/> Child Day Care*                 | <input type="checkbox"/> Nanny Services                            |
| <input type="checkbox"/> Day Care (Senior Citizens)*     | <input type="checkbox"/> Employee Assistance Program               |
| <input type="checkbox"/> Foster Care*                    | <input type="checkbox"/> Referral Agency* (Consultants Supplement) |
| <input type="checkbox"/> Hotlines (Phone Crisis Service) | <input type="checkbox"/> Sheltered Workshop*                       |
|  | <input type="checkbox"/> 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: \_\_\_\_\_

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- 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? If yes, describe: \_\_\_\_\_  Yes  No
- 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)

<u>E</u>	<u>C</u>	<u>E</u>	<u>C</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dietitians/Nutritionists		Physiotherapists/Physical Therapists
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Occupational Therapists		Psychologists/Psychotherapists
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pharmacists		Psychiatrists*
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Physicians*/Dentists*		Speech Therapists
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nurse Practitioners		RNs/LVNs/LPNs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Physician Assistants		Respiratory Therapists
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Social Workers		Case Managers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Marriage/Family Counselors		School Counselors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Teachers		Other: _____

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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?  Yes  No  
If yes, please provide copies of the procedures, including samples of employment applications.

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

**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	Yes
1.					
2.					
3.					
4.					
5.					

If claims-made, what is the most recent retroactive date? \_\_\_\_\_

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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

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# Physician's Exposures Supplement

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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.

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

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# Sexual Misconduct Coverage Supplemental Application

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UNDERWRITERS, INC



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: \_\_\_\_\_

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# 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

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# Pregnancy Centers Supplement



Note: Supplement must be dated and signed by owner, partner, officer, or administrator.

**Please type or print in ink.**

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

1. Applicant Name (including DBAs): \_\_\_\_\_

2. Please list all services offered by the applicant: \_\_\_\_\_

3. Breakdown of patient services (%) by outpatient visits:

- |                                |                            |
|--------------------------------|----------------------------|
| _____ % AIDS                   | _____ % Gynecology         |
| _____ % Alcoholic              | _____ % Nutritional (diet) |
| _____ % Bariatric              | _____ % Obstetrical        |
| _____ % Drug Addiction         | _____ % Pediatric          |
| _____ % Family Planning        | _____ % Psychiatric        |
| _____ % General Exams          | _____ % Substance Abuse    |
| _____ % Other; Describe: _____ |                            |

4. Indicate the number of professional employees, volunteers, and independent contractors:  
**(If none, state none.)**

Physicians, Surgeons & Dentists	No. of Employees and Volunteers	No. of Independent Contractors
a) Physicians: No surgery (other than incisions of boils, suturing of skin, or other obstetrical procedures)		
b) Physicians: Minor surgery or obstetrical procedures not constituting major surgery		
c) Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists Doing Plastic Surgery		
d) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons		
e) Physician's & Surgeon's Assistants, Nurse Practitioners (describe duties on separate sheet)		
f) Unlicensed Interns		

**If any of these categories are providing services, complete the Physician's Exposure Supplement.**

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5. Allied Health Professionals:

	No. of Employees and Volunteers	No. of Independent Contractors		No. of Employees and Volunteers	No. of Independent Contractors
a) EEG/EKG Technician			g) Pharmacist		
b) Medical Lab Tech.			h) Psychotherapist		
c) Nurse Anesthetist			i) Physician's Asst.		
d) Nurse Midwife			j) Radiation Tech.		
e) Nurse Practitioner			k) RN, LVN, LPN		
f) Social Worker			l) Surgical Tech.		

Are all of the above individuals licensed in accordance with applicable state and federal regulations?  
**If no, attach explanation.**

Yes  No

6. Please provide the number of outpatient visits by category.

Type No. of Visits/Tests Clinics - Total	Next Twelve Months	Last Twelve Months
a. Physician	_____	_____
b. Physician Asst./Nurse Practitioner	_____	_____
c. Other Allied Health Professionals	_____	_____
d. Laboratory	_____	_____
e. Surgery (procedures)	_____	_____
f. Imaging/X-Ray	_____	_____
g. Other: _____	_____	_____

7. Does the applicant perform:

a. X-Ray Services?  Yes  No  
 If yes, number of annual X-ray exposures for determination of whether pregnant or not: \_\_\_\_\_  
 The number for tracking development of the fetus through pregnancy or diagnosis: \_\_\_\_\_  
 What qualifications are required of the staff? \_\_\_\_\_

b. Does the applicant prescribe drugs for weight reduction of patients?  Yes  No

c. Are any of the following performed?  Yes  No

- 1) Obstetrics  Yes  No
  - a) Pre-natal  Yes  No
  - b) Deliveries  Yes  No
  - c) Elective or Therapeutic Abortions  Yes  No
  - d) If clinic provides pre-natal care only, do clinic physicians or nurse midwives attend patient at designated hospital at time of delivery?  Yes  No
  - e) If answer to d) is no, are clinic pre-natal records provided to delivering physician and to the designated hospital prior to delivery?  Yes  No
- 2) Chemical/Substance Abuse Services  Yes  No
  - a) Counseling?  Yes  No
  - b) Methadone or similar substances, dispensed or prescribed?  Yes  No
- 3) Do you provide home health care services?  Yes  No

8. Is your facility owned by an M.D.?  Yes  No  
 If yes, owner name(s): \_\_\_\_\_

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9. Does the applicant perform any:
- a. Cosmetic Plastic Surgery?  Yes  No  
Describe: \_\_\_\_\_
  - b. Hysterectomies?  Yes  No
  - c. Surgery for Weight Reduction of Patients?  Yes  No
  - d. Abortions and/or Menstrual Extractions?  Yes  No
  - e. Sterilization Procedures?  Yes  No  
Describe: \_\_\_\_\_
  - f. Biopsies and/or Endoscopies?  Yes  No  
List Types Performed: \_\_\_\_\_
  - g. Other Surgery?  Yes  No  
Describe: \_\_\_\_\_

10. Does the applicant perform gynecology?
- a. Surgical  Yes  No
  - b. Family Planning  Yes  No  
If yes, indicate number of patients: \_\_\_\_\_  
Describe range of services: \_\_\_\_\_

11. Does your clinic require the professional staff be trained in CPR?  Yes  No

12. Describe the referral source(s) by which patients are directed to the entity: \_\_\_\_\_

13. Do you have any restricted licensed physicians on staff?  Yes  No  
If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
Date

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