

Z A S
Zurich Agency Services

**APPLICATION FOR
PROFESSIONAL LIABILITY COVERAGE**

GENERAL INFORMATION:

Applicant: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Person to Contact: _____

Name	Title	Phone Number
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Policy Effective Date: _____ Policy Expiration Date: _____

Type of Business Organization: Non-profit Organization
 Corporation
 Partnership
 Other (specify) _____

Year Business Started or Date of Incorporation: _____

Insured's State of Domicile: _____

Briefly describe the services offered and counseling activities of the Applicant:

COVERAGE:

Limit of Liability Requested: \$100,000/\$300,000
 \$250,000/\$500,000
 \$500,000/\$500,000
 \$500,000/\$1,000,000
 \$1,000,000/\$1,000,000
 \$1,000,000/\$2,000,000
 \$1,000,000/\$3,000,000

(Each Professional Incident/General Aggregate)

Deductible Requested: None \$500 \$1,000 \$5,000
(Each Professional Incident)

If you want to learn more about the compensation Zurich pays agents and brokers visit:
<http://www.zurichnaproducercompensation.com> or call the following toll-free number: (866) 903-1192. This Notice is provided on behalf of Zurich American Insurance Company and its underwriting subsidiaries

PROFESSIONAL LIABILITY

Does the applicant offer any of the following counseling services?

Advanced Mental Health services including counseling for:

- Psychotic
- Manic Depressive
- Suicide Prevention
- Schizophrenic
- Substance Abuse

Other counseling services:

- Foster Care
- Child Placement
- Adoptions
- Sexual / Physical Abuser
- Other Please Explain: _____

Does your Agency have 10 or more full or part-time employed or contracted social workers? Yes No

Does your Agency have 5 or more employed medical professionals? Yes No

Please provide a break down on the following:

Counselors	Employees		Volunteers	
	# Full Time	# Part Time	# Full Time	# Part Time
Graduate Students / BA				
Master's Degrees				
Doctorate Degree (No MD)				
Other Professionally Trained Individuals				

*Full Time = More than 20 hours per week

*Part Time = Less than 20 hours per week

REFERRALS TO OTHER INSTITUTIONS:

Number of Annual Referrals **0 to 100** **101 to 500** **501 to 1000** **Over 1,000**

AGENCY HEALTH CARE SERVICES:

	<u>Total Number of Employees</u>	<u>Total Number of Volunteers</u>
Registered Nurses	_____	_____
Licensed Practical Nurses	_____	_____
Occupational Therapists	_____	_____
Physical Therapists	_____	_____
Speech Therapists	_____	_____
Audiologist	_____	_____

1. The Agency is licensed or certified by: _____
 If not licensed or certified, please explain: _____

2. Is a copy of each Social Worker's license held on file by the Agency? Yes No
 Are procedures in place to verify that a current license is maintained? Yes No

3. What is the caseload of an individual social worker? _____ / _____
Average Maximum

4. How often are Social Worker's cases reviewed by supervisors? _____

5. Has the Agency or any of its employees been reprimanded by, refused admission or suspended before any court, association or administrative agency? Yes No
 Explain: _____

6. Identify the type of records maintained by you for all referral and contracted medical professionals.
 - Certificate of Insurance
 - Copy of Medical Professional Insurance Policy
 Limit of Liability \$ _____
 - State License
 - Certificate of Board Certification

7. Are procedures in place to verify that current licenses and certificates are maintained? Yes No

8. Do any independent referral or contracted medical professionals provide any service at you facility? Yes No

9. Is there a written service or referral agreement between the organization and medical professionals? Yes No

10. Do you employ any M.D.'s, i.e. Doctors, Psychiatrists, Dentists, etc.? (Consult your Insurance Agent for proper insurance coverage.) Yes No

11. Describe the Health Care Services provided by the organization.

Nursing: _____

Therapy: _____

Other: _____

12. Are any services provided for individuals with infectious or contagious diseases? Yes No

13. How long has the organization been providing Health Care services to agency clients? _____

14. Are Health Care Services provided at the agency's facilities? Yes No

15. Do organization employees provide Health Care Services? Yes No
Independent Contractors provide Health Care Services? Yes No
Do others provide Health Care Services? Yes No

16. Describe the records maintained by the organization for providers of the Health Care Services. _____

17. Describe the records maintained by the organization for clients receiving Health Care Services. _____

18. Does the organization provide any of the following Health Care Services?

- Acupuncture Yes No
- Catheterization Yes No
- Feeding Tube Maintenance Yes No
- Psychiatric Shock Therapy Yes No
- X-Rays Yes No
- Respiratory Maintenance Yes No
- Experimental Procedures Yes No

If yes, please explain procedure: _____

19. Is continuing education required by the state for licensing? Yes No
If no, does the organization require continuing education? Yes No

PRIOR INSURANCE

Does the applicant carry Professional Liability Insurance now? Yes No

If yes, describe below:

Insurer _____

Limit of Liability: \$ _____

Deductible Amount: \$ _____

Annual Premium: \$ _____

Inception Date: _____ Expiration Date: _____

Occurrence Form: Yes No

Has the prior carrier indicated an intent not to renew? Yes No

If yes, please explain: _____

PAST CLAIM ACTIVITIES

Describe all previous lawsuits, claims or incidents made against the Applicant involving any allegation of a professional nature during the past five years.

Are you aware of any facts or circumstances, or any actual or alleged act, error or omission, which may result in claims being made against the Applicant or its employees, or its volunteers? Yes No

If yes, please explain: _____

DECLARATION AND SIGNATURE

The Applicant warrants to the best of its knowledge and belief that the statements set forth herein are true and include all material information.

The Applicant further warrants that if the information supplied on this application changes between the date of this application and the inception date of the policy period, it will immediately notify Zurich Commercial of such change. Signing of the application does not bind Zurich Commercial to offer nor the applicant to accept insurance, but it is agreed that this application and any attachments thereto shall be the basis of the insurance and it will be attached and made part of the policy should a policy be issued.

Signature: _____

Title: _____

Date: _____

The following statements are required by the regulations of the state Insurance Departments. It is a required of certain states that this signed statement is attached to the policy. Please read the statement applicable for your state and sign where indicated.

CALIFORNIA APPLICANTS: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT SIGNATURE

DATE

FLORIDA APPLICANTS: PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECIEVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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

APPLICANT SIGNATURE

DATE

NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION

FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

APPLICANT SIGNATURE

DATE

OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

APPLICANT SIGNATURE

DATE

OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECIEVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

PENNSLYVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AND APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, ANY INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS A PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICANT SIGNATURE

DATE

UTAH APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT UNDERWRITING INFORMATION, FILES OR CAUSES TO BE FILED A FALSE OR FRAUDULENT CLAIM FOR DISABILITY COMPENSATION OR MEDICAL BENEFITS, OR SUBMITS A FALSE OR FRAUDULENT REPORT OR BILLING FOR HEALTH CARE FEES OR OTHER PROFESSIONAL SERVICES IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

APPLICANT SIGNATURE

DATE