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

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

REFFERRALS TO OTHER INSTITUTIONS:

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

AGENCY HEALTH CARE SERVICES:

	Total Number of Employees	Total Number of Volunteers
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