



**SOCIAL SERVICE
MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION**
 CLAIMS-MADE **OCCURRENCE**

If this is a claims made policy, please indicate retro date _____

DATE: _____

APPLICANT: _____ PRODUCER: _____

1) Describe professional services provided: _____

2) Is the agency licensed by the state or by another regulatory agency? YES NO
If Yes, please describe: _____

3) Do you have any contractual agreements to provide services? YES NO
If Yes, please describe: _____

4) Total Client Contacts per year _____

5) Does the agency have any residential or inpatient facilities? YES NO
If Yes, what type? _____ # of units/beds _____
Average Occupancy rate _____

If Yes, please attach Residential Care Supplement.

7) Have any claims alleging negligence or failure to comply with any regulatory guidelines been filed against you in the past five years? YES NO
If Yes, please give complete details on a separate sheet.

(In the state of Missouri, the following question does not apply)

8) Has your liability insurance ever been limited, restricted or non-renewed, or have you been denied coverage? YES NO
If Yes, please give complete details on a separate sheet.

9) Does the agency do any foster care placements? YES NO
If Yes, please attach Foster Care Supplement.

10) Please provide the number of each type of caregivers:

Employed FT Employed PT Volunteer FT Volunteer PT Independent Contractor

	Employed FT	Employed PT	Volunteer FT	Volunteer PT	Independent Contractor
Homemaker, Home Health, Nurse's Aide, Sitter, Companion, Bereaval Therapist, Occupational Therapist, Paraprofessional Social Worker, Teacher					
LPN, Social Worker (BA), Dietician, Nutritionist, Dental Hygienist, Pharmacy Assistant, Lab Technician, EKG — Ultrasound Tech, Medical Tech, Echocardiogram Tech, X-ray Tech, Radiology Tech, Certified Medical Asst.					
Clergy, Counselor, RN, Social Worker (MA, MSW), Speech Pathologist, Dialysis Tech, Enterstomal Therapist					
Medical Director					
Pharmacist					
Physical Therapist, Respiratory Therapist, Phlebotomist, Nuclear Medicine Tech, Radiation Therapist					
Psychologist					
Nurse Practitioner, Physician Assistant, Paramedic, EMT					
Psychiatrist, Dentist (attach Physician Information sheet for each)					
Medical Doctor / D.O. / Podiatrist/Acupuncturist (attach Physician Information sheet for each)					
Other (Client Contact only)					

Please include a STAFF PROFILE with your submission.

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or another (NY: other) person files an application for insurance (NY: 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, (NY: 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) and subjects the person to criminal and civil penalties. In Maine and Virginia, insurance benefits may also be denied.

I understand that in order to underwrite professional liability insurance, the Company must have access to information concerning my personal and professional life. I hereby authorize and direct any medical society, medical professional, hospital, residency program, insurance company, underwriter, insurance agent or other entity to furnish any information concerning me or my medical practice which the Company may request. I understand that any policy issued will rely on the truth of the statements and representations I have made herein and that misrepresentations that are fraudulent, or such that the Company would not have issued the policy if the true facts had been known, may result in a denial of coverage for any claim which may be made under this insurance.

Authorized Representative _____ Date _____

Representative's position or title: _____