BENCHMARK MANAGEMENT GROUP
A STANDARD FOR EXCELLENCE

A DIVISION OF
Worldwide Facilities, LLC

Social Services Professional Liability Application for Mental Health/Family Counseling Services

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1 Applicant Name:_____

2 Mailing Address:_____

_____

3 Location Address(es):_____

_____

4 County (parish) of Each Location:_____

_____

5 Telephone Number: Office:_____ Fax:_____

6 Person to Contact for Survey: Name:_____ Title:_____

7 Date Established:_____

8 The applicant is:

[ ] Sole Practitioner
[ ] Sole Proprietorship
[ ] Partnership
[ ] Corporation
[ ] Other; Describe:_____

9 Entity is: [ ] For Profit [ ] Non-Profit

Describe source of funds:_____

PART II. EXPOSURES

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

Last 12 Months: $_____

11 Number of Patient Encounters: Next 12 Months: _____ Last 12 Months:_____

12 Premises Square Footage Area Occupied by Applicant:_____

Are any off-premises services provided? If yes, describe:_____

_____

13 Is the facility Licensed? [ ] Yes [ ] No

If no, explain:_____

_____

14 Service is licensed as:_____

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

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

_____

17 (a) Does applicant conduct group therapy sessions which exceed four (4) hours in duration or more than 25 patients/clients any one occasion? [ ] Yes [ ] No

If yes, give frequency and length of sessions, and # patients/clients:_____

(b) Does applicant conduct any seminars, workshops, or other "group activities" away from regular office premises (including teaching seminars for fellow professionals)? [ ] Yes [ ] No

If yes, give frequency of seminars and # of participants/attendees:_____

18 Does applicant sell, rent, or otherwise distribute any products (including any records, audio tapes, video tapes, films, etc.)? [ ] Yes [ ] No

If yes, describe and give est. receipts:_____

19 Does applicant utilize any of the following modalities in the treatment of more than 50% of applicant's patients/clients?

Hypno Therapy	No ☐	Yes ☐	If yes,_____%
Biofeedback	No ☐	Yes ☐	If yes,_____%
Kinesthetics	No ☐	Yes ☐	If yes,_____%
Psychodrama	No ☐	Yes ☐	If yes,_____%
Bioenergetics	No ☐	Yes ☐	If yes,_____%

20 Does applicant routinely (more than twice in last three years) provide testimony in:

Child Custody Hearing	No ☐	Yes ☐	If yes, # times 3 yrs _____
Competency Hearings	No ☐	Yes ☐	If yes, # times 3 yrs _____

As an expert witness in criminal or civil trials or other legal proceeding? [ ] Yes [ ] No

If yes, # times 3 yrs: _____

21 Does applicant assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying, or apprehending criminal offenders? [ ] Yes [ ] No

If yes, describe and give frequency:_____

22 Does applicant's practice involve the following? If yes, give % of practice, by income, hours, or # of clients.

Child/pediatric Therapy	No ☐	Yes ☐	If yes,_____%
Criminal Offender Therapy/evaluation	No ☐	Yes ☐	If yes,_____%
Therapy for Victims of Criminal Sexual Abuse	No ☐	Yes ☐	If yes,_____%
Therapy for Substance Abusers	No ☐	Yes ☐	If yes,_____%
Crisis Intervention	No ☐	Yes ☐	If yes,_____%
Therapy for Sexual Response/dysfunction	No ☐	Yes ☐	If yes,_____%

23 Does applicant's practice involve the following? If yes, give % of practice and number of clients treated in the last three years. Diagnosis/treatment of:

"Failed/repressed" Memory Syndrome	No ☐	Yes ☐	If yes, # times 3 yrs _____
Multiple Personality Disorder	No ☐	Yes ☐	If yes, # times 3 yrs _____

24 Are any of applicant's patients/clients referred by courts of law or attorneys or other legal representatives of the patient/client? [ ] Yes [ ] No

If yes, give % of patients:_____

PART III. RISK MANAGEMENT

25 Please list all professional staff including degrees held and professional designation:

a) Salaried Employees (W-2):_____

_____

b) Independent Contractors (1099):_____

_____

c) Interns (W-2 or 1099):_____

_____

d) Professional Associates Sharing Premises:_____

_____

26 Does the applicant desire to provide coverage for independent contractor(s), including them as additional insured(s), on your policy while working on your behalf? [ ] Yes [ ] No

If no, do you require contracted staff (if any) to carry their own professional liability insurance? [ ] Yes [ ] No

Do you secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

27 List all memberships in professional organizations:_____

28 Do you enter into contractual agreements to provide professional services? [ ] Yes [ ] No

If yes, enclose copies of all such contracts.

Do you provide services under contract, with said services billed by the other party in lieu of you billing direct for your services? [ ] Yes [ ] No

If yes, identify contract and services provided:_____

_____

_____

_____

29 Do you require staff to report all incidents (accidents) that might result in a liability claim, are records of such reports kept on file by you? [ ] Yes [ ] No

If not, are you agreeable to instituting this procedure? [ ] Yes [ ] No

Enclose copy of your letterhead, brochures, and advertising.

30 Unless otherwise noted hereunder, the following are true statements with regard to the applicant:

a) Applicant, including employees and independent contractor, is not a principal with any health care-related partnership, association or corporation, nor is applicant a proprietor, superintendent, officer, director, stockholder or member of the board of directors, trustees, or governors of any health care-related business enterprise;

b) Applicant does not provide billing or collection services for any other professional person or organization;

c) Applicant does not share staff with any other professional person or organization;

d) Applicant does not share office premises with any psychiatrist or any other physician;

e) Applicant, including employees and independent contractors, is not licensed or authorized to provide any other professional services except as stated in application;

f) Applicant, including employees and independent contractors, has never had his/her license or certification revoked or suspended, not been the subject of any disciplinary proceeding, not been reprimanded by an administrative agency, professional association, or peer committee;

g) Applicant, including employees and independent contractors, has never had a claim or suit brought against him/her because of any alleged malpractice, error or mistake arising out of his/her professional services, and applicant is aware of any circumstances that might result in such a claim or suit.

Exceptions, if any, to above (no answer means "no exceptions"):_____

PART IV. HISTORY

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

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

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

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

33 Requested Limits of Liability (if available):

Professional Liability $_____ Each Medical Incident/ $_____Aggregate

General Liability $_____ Each Occurrence/ $_____General Aggregate

34 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? [ ] Yes [ ] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

_____

_____

_____

_____

35 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? [ ] Yes [ ] No

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 JaVA Underwriting, LLC, 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 dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

_____

Applicant Signature

_____

Title

_____

Date

Mental Health Practitioners Exceptions Supplement
(Individual Coverage)

Unless otherwise noted hereunder, the following are true statements applicable to the insured:

a) Insured does not conduct group therapy sessions which exceed four (4) hours in duration;

b) Insured does not conduct any seminars, workshops, or other "group activities" away from his/her regular office premises that involve more than twenty-five (25) patients/clients in any one occasion;

c) Insured does not sell, rent, or otherwise distribute any products (including but not limited to any records, audio tapes, videotapes, films);

d) Not more than twenty-five percent (25%) of the insured's practice (by income, hours, or # of clients) involves: i) criminal or sex abuse offender therapy or evaluation, or ii) therapy for victims of sex abuse;

e) Insured does not routinely (more than five in last three years) provide testimony i) in child custody hearings, ii) in competency hearings, iii) as an expert witness in legal proceedings;

f) Insured does not assist law enforcement organizations or officers by providing forensic or other services intended for evidencing, identifying, or apprehending criminal offenders;

g) Not more than fifty percent (50%) of insured's practice (by income, hours of service, or number of patients/clients) involves the following:

   i) child/pediatric therapy

   ii) therapy for substance abusers

   iii) crisis intervention

   iv) therapy for sexual response/dysfunction

   or the following modalities in treatment

   v) hypnotherapy

   vi) biofeedback

   vii) kinesthetics

   viii) psychodrama

   ix) bioenergetics;

h) Insured's practice does not involve treatment for dissociative disorder not otherwise specified, commonly referred to as “false memories disorder” or “repressed memory disorder;”

i) Insured's practice does not involve treatment for dissociative identity disorder (multiple personality disorder);

j) Not more than twenty-five percent (25%) of insured's patients/clients are referred (or remanded) by courts of law or attorneys or other legal representatives of the patient/client;

k) Insured does not provide billing or collection services for any other professional person or organization;

l) Insured does not share office premises with any psychiatrist or any other physician;

m) Insured is not licensed or authorized to provide any other professional services;

n) Insured has never had his/her license or certification revoked or suspended, nor been the subject of any disciplinary proceeding, nor been reprimanded by any administrative agency, professional association, or peer committee;

o) Insured has never had a claim or suit brought against him/her because of any alleged malpractice, error, or mistake arising out of his/her professional services, and insured is aware of any circumstances that might result in such a claim or suit.

Exceptions, if any, to above (absence of entry means "no exceptions"):_____

_____

_____