HUNTERSURE LLC

OUTPATIENT MENTAL HEALTH COUNSELING PROFESSIONAL and GENERAL LIABILITY APPLICATION (Edition 04.01.24)

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple name and locations, please attach list)

4. Telephone Number: _____ Fax Number: _____ Website: _____

5. a.) Date Established: _____

b.) Entity Type: Corp. _____ Partnership_____ Prof. Assoc. _____ Individual_____

c.) For Profit _____ Non-Profit _____

6. a.) Desired Effective Date: _____

b.) Desired Limits of Liability: $_____ / $_____

c.) Desired Deductible: $_____

7. a.) Gross Receipts for Past 12 Months: $ _____ b.) Est. Gross Receipts for Next 12 Months: $ _____

c.) Payroll for Past 12 Months: $ _____ d.) Est. Payroll for Next 12 Months: $ _____

e.) # of Visits for Past 12 Months: _____ f.) Est. # of Visits for Next 12 Months: _____

8. Applicant's Service is licensed: _____

9. Full description of services provided: _____

10. Does the applicant have any ancillary operations not stated above? Yes: _____ No: _____

If Yes, please provide details: _____

11. Is the applicant engaged in, owned by, associated with, or controlled by any other business?

Yes: _____ No: _____ If Yes, please provide details: _____

_____

12. Are all services provided at the applicant's location address(s)? Yes: _____ No: _____

If No, please provide details of any off-site exposure: _____

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

14. Please provide a breakdown of the types of counseling services provided and exposures below:

Substance Abuse (Alcohol/Drugs)	_____ %
Ex-Offender Therapy/Evaluation	_____ %
Crisis Intervention	_____ %
Family	_____ %
Marriage	_____ %
General	_____ %
Child/Pediatric	_____ %
Victims of Domestic/Sexual Abuse	_____ %
Suicidal or Self-harming behaviors	_____ %

Other (please describe): _____

15. Does the applicant use hypnotherapy, treatment for failed/repressed memory syndrome, or use any alternative/non-traditional counseling methods as part of their practice? Yes: _____ No: _____

If Yes, please provide details of methods used and what percentage this is of their total operation:

_____

_____

16. Does the applicant provide any of the following services:

a.) Provide testimony in child custody hearings? Yes: _____ No: _____
If Yes, # times in past 3 years: _____

b.) Provide testimony in competency hearings? Yes: _____ No: _____
If Yes, # times in past 3 years: _____

c.) Act as an expert witness in criminal/civil trials or other legal proceedings? Yes: _____ No: _____
If Yes, # times in past 3 years: _____

d.) Treat patients referred/remanded by courts of law or attorneys or any other legal representative of the patient/client?
Yes: _____ No: _____ If Yes, give percentage of patients: _____

17. a.) List the number and type of **EMPLOYEES**: (if none, state none)
(If Owner Operated, please provide details on backup plan if the owner is unavailable)

	# Part-time	# Full-time		# Part-time	# Full-time
Registered Nurse	_____	_____	Physician (patient contact)	_____	_____
Licensed Practical Nurse	_____	_____	Physician (medical director only)	_____	_____
Social Worker	_____	_____	Counselor	_____	_____
Nurse Practitioner	_____	_____	Medical Technician	_____	_____
Physician Assistant	_____	_____	Psychiatrist	_____	_____
Paramedic/EMT	_____	_____	Psychologist	_____	_____
Other (please describe):	_____	_____	Clerical/Admin	_____	_____

_____

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b.) List the number and type of **INDEPENDENT CONTRACTORS**:

	# Part-time	# Full-time		# Part-time	# Full-time
Registered Nurse	_____	_____	Physician (patient contact)	_____	_____
Licensed Practical Nurse	_____	_____	Physician (medical director only)	_____	_____
Social Worker	_____	_____	Counselor	_____	_____
Nurse Practitioner	_____	_____	Medical Technician	_____	_____
Physician Assistant	_____	_____	Psychiatrist	_____	_____
Paramedic/EMT	_____	_____	Psychologist	_____	_____
Other (please describe):	_____	_____	Clerical/Admin	_____	_____

_____

c.) Are all individuals shown in response to questions 17 a and b who are subject to state or federal licensing requirements so licensed? Yes: _____ No: _____ If No, attach explanation.

18. Do you require independent contractors (if any) to carry their own Professional Liability Insurance and secure certificates of Insurance as evidence of such coverage? Yes: _____ No: _____
If Yes, what is the minimum limit required? $ _____ / $ _____

If No, is coverage desired with shared limits on this policy? Yes: _____ No: _____

19. Do you require employed physicians, psychologists, psychiatrists and/or counselors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

Yes: _____ No: _____ If Yes, at what limits? $_____ / $_____

20. Does the applicant provide any beds for overnight stays? Yes: _____ No: _____
If Yes, please describe: _____

21. Do you sell, rent, or otherwise provide any equipment to products or others? Yes: _____ No: _____
If Yes, give details including types of products and gross receipts from each:
_____

22. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician?

Yes: _____ No: _____ If No, give details: _____

23. a.) Do you conduct pre-employment screening and investigation? Yes _____ No _____

b.) Are employees required to actively participate in continuing education? Yes _____ No _____

c.) Do you prepare job descriptions and instructional manuals for your staff? Yes _____ No _____

d.) Do you have a written incident/occurrence reporting policy and procedures? Yes _____ No _____

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24. Check all the following that apply if obtained, verified and kept on file as part of the employee hiring and screening process:

Applications / Resumes	_____	Criminal Background Checks	_____
Drug Testing	_____	Licenses Held	_____
Education/Training/Competence	_____		

25. Is the applicant a member of any association or certified or accredited by any governing body?

Yes: _____ No: _____ If Yes, give details: _____

26. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a.) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?	_____	_____
b.) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c.) Ever been treated for alcoholism or drug addiction?	_____	_____
d.) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	_____	_____

27. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?

Yes: _____ No: _____ If Yes, give details, including name, location size and number of beds.

_____

28. Give Professional Liability coverage for last 5 years: (if none, state none)

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

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29. Give General Liability coverage for last 5 years: (if none, state none)

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

30. Is the applicant aware of any circumstances which may result in any claim against the proposed insured entity or any individual who would be covered by this policy?

Yes: _____ No: _____ If Yes, please give details _____

31. Has any insurer cancelled or refused to renew any similar insurance during the past 5 years?

Yes: _____ No: _____ If Yes, please give details _____

32. Has any claim been made against the proposed insured or any of its employees in the last 5 years?
Yes: _____ No: _____
If Yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

33. Is the applicant aware of any circumstances which may result in any claim against the insured or any of its employees that would be covered by this policy?
Yes: _____ No: _____ If Yes, please give full details_____

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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(NOTE: Application must be signed by the owner or president or principal)