



PROFESSIONAL and GENERAL LIABILITY APPLICATION OUTPATIENT MENTAL HEALTH COUNSELING (Edition 06.2026)

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Location Address: _____
(If multiple names and locations, please attach list)
4. Telephone Number: _____ Website Address: _____ Date Established: _____

Section 2: Business Details

5. Entity Type: ☐ Corporation ☐ Individual ☐ LLC ☐ Partnership ☐ Other: _____
6. Status: ☐ For Profit ☐ Non-Profit
7. Funding is: Medicare _____% Medicaid _____% Private Pay _____% Other: _____

Section 3: Coverage Requested

8. Effective Date: _____
9. Liability Limits: \$ _____ / \$ _____
10. Deductible: \$ _____

Section 4: Financial Information and Operations

11. Gross Receipts (Past 12 Months): \$ _____
12. Estimated Gross Receipts (Next 12 Months): \$ _____
13. Number of Outpatient Visits (OPVs) (Past 12 Months): _____
14. Estimated Number of Outpatient Visits (OPVs) (Next 12 Months): _____

Section 5: Services Provided

15. Full description of services provided: _____

16. Does the applicant have any ancillary operations not stated above? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 3 of this application? ☐ Yes ☐ No



17. Is the applicant engaged in, owned by, associated with, or controlled by any other businesses? ☐ Yes ☐ No
If Yes, please provide details: _____
- If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 3 of this application? ☐ Yes ☐ No
18. Are all services conducted exclusively at the applicant's listed location address(es) shown on Q3? ☐ Yes ☐ No
If No, please provide details regarding any off-site services or exposures: _____
19. Does the applicant's scope of services involve physical contact with or between patients/clients? ☐ Yes ☐ No
If Yes, please describe: _____
20. Please indicate the percentage of total professional services represented by each counseling service below (must total 100%):
- | | |
|--|---------|
| a) Substance Abuse (Alcohol/Drugs) | _____ % |
| b) Ex-Offender Therapy/Evaluation | _____ % |
| c) Crisis Intervention | _____ % |
| d) Family Counseling | _____ % |
| e) Marriage Counseling | _____ % |
| f) General Counseling | _____ % |
| g) Child / Pediatric Counseling | _____ % |
| h) Victims of Domestic or Sexual Abuse | _____ % |
| i) Suicidal or Self-Harming Behaviors | _____ % |
| j) Other (please describe): _____ | _____ % |
21. If Crisis Intervention services are provided (Q20c), please provide full details of these services, including the types of crises addressed and the specific interventions implemented in response to such situations. ☐ N/A

22. Does the applicant provide hypnotherapy, treatment for failed or repressed memory syndrome, or engage in any alternative or non-traditional counseling techniques? ☐ Yes ☐ No
If Yes, please provide details of the methods utilized and the percentage these services represent of the applicant's total operations:

23. Does the applicant provide any of the following services?
- | | |
|---|--|
| a) Testimony in child custody proceedings.
If Yes, number of times provided during the past three (3) years: _____ | ☐ Yes ☐ No |
| b) Testimony in competency or capacity proceedings.
If Yes, number of times provided during the past three (3) years: _____ | ☐ Yes ☐ No |
| c) Expert witness services in criminal, civil, administrative, or other legal proceedings.
If Yes, number of times provided during the past three (3) years: _____ | ☐ Yes ☐ No |
| d) Treatment or counseling services for individuals referred, ordered, or remanded by a court, attorney, probation department, or other legal authority.
If Yes, approximate percentage of total patients/clients: _____ % | ☐ Yes ☐ No |

24. Does the applicant conduct and document pre-treatment screenings for suicidal ideation, self-harm, or threats of harm to others (and refer to an appropriate provider or level of care if such risks are identified during treatment)? ☐ Yes ☐ No

Section 6: Staffing

25. Employee and Independent Contractor Details:

a) List the **NUMBER** and type of **EMPLOYEES**:

(If owner-operated, describe contingency plans in the event of owner unavailability)

EMPLOYEES	FULL-TIME	PART-TIME	EMPLOYEES	FULL-TIME	PART-TIME
Behavioral Analyst			Physician (Patient contact)		
Registered Nurse (RN)			Physician (Medical Director Only)		
Social Worker			Counselor		
Nurse Practitioner (NP)			Psychiatrist		
Physician Assistant (PA)			Psychologist		
Paramedic / EMT			Clerical / Administrative		
Medical Technician			All Others (Describe)		

b) List the **NUMBER** and type of **INDEPENDENT CONTRACTORS**: ☐ If None

CONTRACTORS	FULL-TIME	PART-TIME	CONTRACTORS	FULL-TIME	PART-TIME
Behavioral Analyst			Physician (Patient contact)		
Registered Nurse (RN)			Physician (Medical Director Only)		
Social Worker			Counselor		
Nurse Practitioner (NP)			Psychiatrist		
Physician Assistant (PA)			Psychologist		
Paramedic / EMT			Clerical / Administrative		
Medical Technician			All Others (Describe)		

c) Are all individuals listed on Q25 subject to licensing requirements properly licensed? ☐ Yes ☐ No

If No, explain: _____

26. Are you seeking coverage under this proposed insurance for the independent contractors? ☐ Yes ☐ No
If No, is coverage at equal or greater limits maintained by each independent contractor? ☐ Yes ☐ No

27. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists, or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No

If Yes, provide required limits: \$_____ / \$_____



28. Does the applicant provide any on-site accommodations or beds for overnight stays? ☐ Yes ☐ No
If Yes, please provide a detailed description, number of beds, including purpose and frequency of use:

29. Are patients accepted for health care services only pursuant to a written plan of treatment established by an attending physician? ☐ Yes ☐ No
If No, please provide details: _____

Section 7: Employee Screening / Controls

30. 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
31. Check all the following that are collected, verified, and maintained for each staff member during the hiring process:
- | | | |
|---|--|--|
| ☐ Applications/Resumes | ☐ Criminal Background Checks | ☐ Licensure Verification |
| ☐ Drug Testing | ☐ Education/Training/Competence | ☐ Sex Abuse Registry Checks |

Section 8: Regulatory and Inspection

32. Disclosure of Disciplinary or Legal History:
Attach a detailed explanation for any **YES** answers below:
Has the applicant or have any of the employees:
- a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
- b) Ever been convicted of any act committed in violation of any law or ordinance (other than traffic offenses)? ☐ Yes ☐ No
- c) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
- d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms, or voluntarily surrendered? ☐ Yes ☐ No

Section 9: Insurance History

Currently valued loss runs for all prior coverage are required.

33. Professional Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a **claims-made** policy, provide retroactive date: _____



34. General Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

Section 10: Claims and Incidents

35. Has any insurer canceled or refused to renew similar insurance in the past 5 years?
(If Yes, attach details) ☐ Yes ☐ No

36. Has any claim been made against the insured or its employees that would be covered by this
policy in the past 5 years? ☐ Yes ☐ No

If Yes, please attach a completed Huntersure Claims Supplement (one for each claim or incident reported)

37. Is the applicant aware of any circumstances that may result in a claim against the insured or its employees
that would be covered under this policy? (If Yes, attach details) ☐ Yes ☐ No

Signature and Attestation

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.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date, time stamp, and originating email address.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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

huntersure.com

Page 5 of 5