Member Companies of Western World Insurance Group

☐ Western World Insurance Company
☐ Tudor Insurance Company
☐ Stratford Insurance Company

Application For **Counseling Centers, Therapy Centers & Individual Professionals (Prof./GL)**

1. Name of Applicant____

   Street Address____

   City_____________________________ State______________ Zip__________

   Applicant's Web Site Address____

2. [ ] Individual [ ] Corporation [ ] Partnership [ ] Professional Association

   [ ] Other (Explain)____

3. List full name of individual or partners and their interests:____

   ____

4. Date established:__________________________

5. Indicate applicant's professional specialty (see questions 26-31):____

   ____

6. Provide full details of operations including daily duties and job description:____

   ____
   ____
   ____
   ____
   ____

7. Check all procedures you use when hiring professional, paraprofessional, or any other employee who will provide patient care services at your facility.

	None	Verbal	Written
a. Educational background or residency program check, when applicable.	[ ]	[ ]	[ ]
b. Previous employers check.	[ ]	[ ]	[ ]
c. Personal references check.	[ ]	[ ]	[ ]
d. Check for any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals.	[ ]	[ ]	[ ]
e. Police background check.	[ ]	[ ]	[ ]

   If any answer is "None", refer to company.

8. Please list the number and specialties of employed professionals:____

   ____

9. Do you want your policy to cover your employees for their liability? There is a charge. [ ] Yes [ ] No
   NOTE: The policy already protects *you* for the acts of your employees.

10. AUDIT -- Your premium will be **adjustable** on your exposure. If you exceed your estimated sales, outpatient visits or other rating units, your premium will increase.

    Enter name and phone # of your audit contact person.____

    Enter address where business records are kept. ____

11. Are you in private practice? [ ] Yes [ ] No Are you an employee? [ ] Yes [ ] No
Indicate percent of time spent in the following work locations:

________% Administrative office ________% Outpatient clinic ________% Classroom

________% Laboratory ________% Emergency Dept. of hospital ________% Patient's home

________% Professional office ________% Nursing home ________% Operating room

________% Hospital ward (specify)____

________% Other____

12. If services performed are counseling, please indicate % of total counseling:

________% Family planning ________% Drug detoxification ________% S.T.D.

________% Abortion* ________% Drug methadone ________% Alcohol

________% Legal* ________% Family ________% Adoption screening*

________% Marital ________% Criminal* ________% Foster Care screening*

________% Sexual offenders* ________% Crisis intervention* ________% Domestic abuses*

________% Narcotics ________% Hot line* ________% Other (specify)

*If any, provide specifics.

13. a. If a "For-Profit Corp.", previous 12 months gross sales: $______________________________

Anticipated gross sales for policy period: $______________________________

b. If a "Not-For-Profit", previous 12 months outpatient visits: ______________________________

Anticipated outpatient visits for policy period: ______________________________

Operating budget or funding: $______________________________

c. Anticipated number of "Hot Line" calls for policy period: ______________________________

d. Is applicant engaged in, associated with or involved in any other enterprise? [ ] Yes [ ] No
If yes, provide details____

14. List any professional association of which applicant is a member:____
____

15. Describe any professional training, licensing or certification needed for this operation:______________________________
____

16. What state/s are you licensed or certified in and provide details of what your license/certification allows you to do?
____
____
____

17. If you are an employee, please describe your management or supervisory duties:______________________________
____

18. If you contract your services to others on an independent contractors basis, whom do you work for?__________________
____

19. Prior insurance carrier and loss history (If none, check here [ ]):

Year	Insurance Company	Policy Number and Premium	Loss Paid & Reserved	Loss Description

20. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s)? If yes, provide details. Include description of claim, date of loss, amount(s) paid and reserved. [ ] Yes [ ] No

____

____

21. Is applicant, or any other person for whom coverage is being requested, aware of any circumstances which may result in a claim? If yes, provide details. [ ] Yes [ ] No

____

____

22. Has applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, or any policy cancelled or non-renewed in the past five (5) years? If yes, please provide details.______________________________ [ ] Yes [ ] No

____

____

23. Limit of insurance requested.

General Aggregate Limit (Other than Products - Completed Operations)	$______________	
Products-Completed Operations Aggregate Limit	$______________	
Personal and Advertising Injury Limit	$______________	any one person or organization
Each Occurrence Limit	$______________	
Damage to Premises Rented to You (up to $50,000 limit available)	$______________	any one premise
Medical Expense Limit (up to $5,000 limit available)	$______________	any one person
Each Professional Incident Limit (if applicable)	$______________	

24. Effective Dates Desired: From___________________________________ To_______________________________________

25. If only professional coverage is desired, name your general liability insurer. Also, give your policy number, policy limits, and the effective date.

____

____

26. Please answer the questions applicable to your professional specialty:
Physical therapists:

- If involved with sports-related therapy, what level: [ ] Amateur [ ] High School [ ] College [ ] Semi-pro [ ] Professional
- If therapy center is renting equipment for in-home use, what type?____

  ____
- Are any Masseuse/r employed? If so, what type if license/certification?____

  ____
- Are there any Chiropractors employed?____

  ____

27. Occupational therapy:
Do you require physician's sign-off for client's to return to work? [ ] Yes [ ] No

28. Counselor/Social work:
   - Provide details of any legal or financial advocacy services:____
   ____
   - Do you provide court-appointed "supervised visitation" services? [ ] Yes [ ] No

     If yes, how many in past 12 months?____________________________

     Are they on or off your premises?________________________________

   - Are you involved with prison release or probation programs? [ ] Yes [ ] No
     If yes, please explain (also number in past 12 months):____
   ____
   - Are you using obstacle or wilderness courses in conjunction with counseling programs? [ ] Yes [ ] No
     Please provide details of course and supervision:____
   ____

29. Nursing:
   - If you work in patient's homes, do you administer I.V. or chemotherapy? [ ] Yes [ ] No
     Describe any special training:____
   ____
   - Do you have operating room duties? [ ] Yes [ ] No
   - Do you have OB/GYN or midwife activities? [ ] Yes [ ] No
   - Are you involved in experimental medical programs? [ ] Yes [ ] No

30. Diet centers/dietitian:
   - Describe the lowest calorie diet which you prescribe:____
   ____
   - List any vitamins prescribed/administered:____
   ____
   - List any herbal, homeopathic or natural supplements prescribed/administered:________________________________
   ____
   - Are prescribed/administered items FDA approved? Provide label and/or brochure:________________________________
   ____
   - List any foods or other products sold:____
   ____
   - Are any physicians employed? [ ] Yes [ ] No
   - Are any physicians contracted? [ ] Yes [ ] No
     If yes, what limits of professional insurance do they carry?____
   ____

31. Druggist/Drug Stores
    Can druggist prescribe medications?:____
    ____

IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE ANSWER THE FOLLOWING QUESTIONS.

32. Please indicate the liability limits you are requesting.
    [ ] $25,000/50,000 [ ] $50,000/100,000 [ ] $100,000/300,000 [ ] $300,000/300,000

33. Please describe your hiring practices. ____
    ____

34. Do you have written guidelines regarding sexual misconduct? [ ] Yes [ ] No

35. What steps have you taken to prevent or avoid a sexual misconduct incident?
    (e.g. same gender caregiver/client)____
    ____

36. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? If yes, give details. ______________________________ [ ] Yes [ ] No

____

37. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? If yes, give details. ______________________________ [ ] Yes [ ] No

____

38. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? If yes, give details. ______________________________ [ ] Yes [ ] No

____

Notice to applicants: In most states any person who knowingly and with intent to defraud files an application for insurance containing any materially false information, or conceals for the purposes of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime.

Applicant's Signature: ______________________________

Title:______________________________

Date:______________________________

Producing Agent's Signature:______________________________

Date:______________________________

Upon requesting quotes and/or placement for the coverage listed herein, the producing retail broker hereby confirms that he/she has performed any and all diligent searches, as may be required by statute, for coverage through licensed carriers or other means of placement. Where allowed by governing statutes, "diligent effort" may not require an actual physical search and declination on each risk, but may be based on the retail producing broker's own experience, opinion and overall knowledge of acceptability in the admitted marketplace.