Member Companies of Western World Insurance Group

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

Application
For

Counseling Center, 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 24-28): _____

6. Full description of operations: _____

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 receipts, 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 receipts: $ _____

Anticipated receipts 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. If you are an employee, please describe your management or supervisory duties: _____

_____

17. If you contract your services to others on an independent contractor basis, whom do you work for? _____

_____

18. Prior insurance carrier and loss history (If none, check here ☐):

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

19. 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

_____

_____

20. 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

_____

_____

21. 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

_____

_____

22. Limits of insurance requested.

General Aggregate Limit (Other than Products – Completed Operations)	$ _____
Products-Completed Operations Aggregate Limit	$ _____
Personal and Advertising Injury Limit	$ _____
Each Occurrence Limit	$ _____
Fire Damage Limit (up to $50,000 limit available)	$ _____ any one (1) fire
Medical Expense Limit (up to $5,000 limit available)	$ _____ any one (1) person
Each Professional Incident Limit (if applicable)	$ _____

23. Effective Dates Desired: From _____ To _____

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

_____

25. 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? _____

_____

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

27. 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 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: _____

_____

28. 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

29. Diet centers/dietician:

- Describe the lowest calorie diet which you prescribe: _____
- List any vitamins prescribed/administered: _____
- List any foods or other products sold: _____
- Are any physicians employed or contracted? ☐ Yes ☐ No
  If yes, what limits of professional insurance do they carry? _____

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

30. Please indicate the liability limits you are requesting.
☐ $25,000/50,000 ☐ $50,000/100,000 ☐ $100,000/300,000 ☐ $300,000/300,000

31. Please describe your hiring practices. _____

32. Do you have written guidelines regarding sexual misconduct? ☐ Yes ☐ No

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

34. 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 _____

35. 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 _____

36. 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 hereto, commits a fraudulent act, which is a crime.

Applicant's Signature: _____

Title: _____

Date: _____

Producing Agent: _____