FOR OFFICE USE ONLY
PREMIUM:
RATED BY:
EFFECTIVE DATE:
RETRO DATE:
REFUND AMOUNT DUE:

Allied World Insurance Company ("Insurer")

Return and make checks payable to:
American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

RENEWAL APPLICATION FOR PSYCHIATRIC NURSE PRACTITIONER/PHYSICIAN ASSISTANT PROFESSIONAL/ADVANCE PRACTICE REGISTERED NURSE PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

Notice to Florida Applicants:
License # L045052 issued to Peter Imbert

Notice to Iowa Applicants:
License # 3000928232 issued to Peter Imbert

Notice to California Applicants:
License #0555091 issued to American Professional Agency, Inc.

THIS APPLICATION IS FOR COVERAGE TYPE: ☐ **CLAIMS-MADE** ☐ **OCCURRENCE-BASED**

NOTICE: THE COVERAGE OF A CLAIMS-MADE POLICY IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED, OR PROCEEDINGS FIRST BROUGHT, DURING THE POLICY PERIOD, AND REPORTED IN WRITING TO THE INSURER IN ACCORDANCE WITH THE TERMS OF THE POLICY. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR LEGAL OR INSURANCE ADVISOR.

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE SECTION V. (C). "MAXIMUM LIMIT OF LIABILITY - SEXUAL MISCONDUCT" IN THE POLICY).

- This Application must be completed in full, including all required attachments. Write "None" if that applies.
- Attach a separate sheet of paper if more space is needed to answer any question.
- We treat all Applications as confidential. If additional assurances of confidentiality are required, we are willing to address the Applicant's needs.

PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION

1. a. Name of Applicant _____ Policy No.:_____

E-mail address: _____

b. Professional Designation (check one): ◯ Nurse Practitioner ◯ Physician Assistant ◯ Advance Practice Registered Nurse

II. APPLICANT INFORMATION

2. a. Principal Office Address: _____

_____

(City) (County) (State) (Zip)

Entity and/or Facility Name: _____

Note: If you have been practicing at this location fewer than 3 years, please provide us with your previous location on a separate sheet of paper and the length of time at that location.

b. Any Other Office Address: _____

_____

(City) (County) (State) (Zip)

Entity and/or Facility Name: _____

c. Home Address: _____

_____

(City) (County) (State) (Zip)

d. If you are practicing in multiple locations which are located in different counties and/or states, please provide a percentage of time spent in each location.

3. To which of these addresses do you wish correspondence sent? ☐ 2a ☐ 2b ☐ 2c

4. Office Telephone: ( ) _____ Fax #: ( ) _____ Home Telephone: ( ) _____

5. a. Change in Policy Limits Requested? _____ / _____

b. Are you interested in obtaining limits higher than $5,000 for defense expenses related to licensing board investigations and other proceedings as described in the Policy? ☐ Yes ☐ No

If yes, choose higher limit of liability desired for defense expenses related to licensing board investigations and other proceedings as described in the Policy:

☐ $10,000 (Additional Premium $75) ☐ $25,000 (Additional Premium $95) ☐ $50,000 (Additional Premium $110)

☐ $75,000 (Additional Premium $171) ☐ $100,000 (Additional Premium $232) ☐ $125,000 (Additional Premium $293)

☐ $150,000 (Additional Premium $354)

Please include the additional premium indicated with your premium payment.

III. PRACTICE INFORMATION

6. Have any of your responses to Questions 7 through 16 below changed since your completion of the prior application for this coverage?

☐ Yes ☐ No

If yes, please respond to Questions 7 through 16 below.

If no, please go directly to Section IV. of this Application.

7. a. Name of physician or clinic you will be working for: _____

   b. Policy No.: _____ Name of supervising physician: _____

   c. Is your supervising physician a psychiatrist? ☐ Yes ☐ No

8. Desired effective date of coverage: _____ Number of hours worked per week: _____

9. Practice address: _____
   (street) (city) (state) (zip) (phone)
   Entity and/or Facility Name: _____

10. Will you be working at the same location as your supervising physician? ☐ Yes ☐ No

    If no, where will you be working? _____

11. Do you have a written collaboration agreement with your supervising physician? ☐ Yes ☐ No

    How often will your charts be reviewed? _____

12. Do you have written protocols? ☐ Yes ☐ No

13. a. List your name and qualifications.

Name	Degree	Field of Study	Professional Association Membership		Number of hours practice each week	License or Certification			
			Associa-tion name	Member-ship Level		First Year Licensed	State	Title	Board Certified? Yes/No

   b. **Please attach a copy of your Curriculum Vitae (C.V.).**

14. PRACTICE PROFILE

   a. Composition of your practice: Children/Adolescents/Related Adults_____% Prisoners_____%
   Adults (not related to above) _____% Sex Offenders_____% Custody Evaluation _____%
   If your practice includes prisoners, is this a correctional facility? ☐ Yes ☐ No
   If yes, is insurance coverage provided for these activities by such facility? ☐ Yes ☐ No

   b. Do you have admitting privileges? ☐ Yes ☐ No
   If no, please describe your mechanism for handling your patients who may require immediate in-patient care:
   _____

   c. Do you create and maintain a psychiatric/medical record for each patient under your care? ☐ Yes ☐ No
   If no, please explain: _____

   d. Do you have prescriptive authority? ☐ Yes ☐ No If yes, what Schedule? _____
   If no, please provide the name and clinical specialty of the physician who will write prescriptions:
   _____

e. Do you obtain an informed consent, whether signed by the patient or noted in the chart, before prescribing medication? ☐Yes ☐No

f. Do you regularly treat general medical conditions presented by your psychiatric patients? ☐Yes ☐No

If yes, please indicate: (1) Average number of patients per week you provide treatment to: _____

(2) Nature of the conditions you treat and the type of treatment you provide: _____

_____

g. Do you advertise as a specialist* in the evaluation and treatment of any of the following?

☐Borderline Personality Disorder ☐Chronic Pain ☐Multiple Personality Disorder or Dissociative Disorders

☐Childhood Sexual Abuse ☐Eating Disorder ☐Sex Therapy

***Note**: "Specialist" is indicated by 1) advertisements, 2) marketing materials, 3) letterhead, or 4) employment, contractual relationship or admitting privileges at any institution with a special interest in any of the above.

h. Does your treatment include use of abreaction, rage, sodium amytal, sex or recovered memory therapies? ☐Yes ☐No

If yes, please explain the clinical details regarding this treatment._____

_____

i. Does your practice include forensic activities, e.g. child custody and visitation, criminal responsibility; competence, civil and criminal; correctional psychiatry; juvenile justice and violence? ☐Yes ☐No

What is the percent of your total practice time devoted to this activity? _____%

On a separate sheet, please explain the exact type of forensic activities.

j. Do you communicate with your patients via e-mail? ☐Yes ☐No

Please explain the nature of communications in detail._____

k. Does your practice include telemedicine activities, e.g. the transfer of data through electronic (video or computer) means in order to provide healthcare to patients who are geographically separated from the clinicians involved? ☐Yes ☐No

What is the total practice time devoted to this activity? _____%

On a separate sheet, please explain the exact type of telemedicine activities.

l. Do you engage in any clinical trials and/or pharmaceutical research? ☐Yes ☐No

If yes, does the sponsor agree in writing to indemnify you for such research activities? _____

(Please include a copy of these indemnification agreements.)

If no, please explain type and extent of such activities: _____

m. Do you treat patients with unconventional therapy, i.e. treatment not considered to be mainstream psychiatric treatment?

☐Yes ☐No

If yes, please describe: _____

n. Do you cover any ER for crisis cover? ☐Yes ☐No

If yes, please indicate percentage of time devoted to this activity: _____%

Is this on call? ☐Yes ☐No

If yes, approximately how many hours per week? _____

15. a. Are you engaged in self-employment, paid consultation or private practice? ☐Yes ☐No

b. Are you employed (W2 form employee)? ☐Yes ☐No

If yes, employed by: _____

c. Are you a salaried employee of any organization other than the firm listed in Question 2a? ☐Yes ☐No

If yes, please explain:_____

d. Do you own, partly own, manage or exercise any form of fiduciary control over any business enterprise or medical practice? ☐Yes ☐No

If yes,:

i. Please explain the nature of the enterprise. _____

ii. Please provide a count of employees by type. _____

16. a. Are you on the staff of, or affiliated with, any hospital, clinic, group home or nursing home? ☐Yes ☐No

If yes, please list institution, nature of work and hours per week. _____

_____

b. Are you provided malpractice coverage by a facility or place of employment, or any other policy that covers you? ☐Yes ☐No

If yes, please indicate location of the facility or place of employment and limits provided._____

c. Do you have any direct or indirect financial interest in any hospital, pharmacy, diagnostic or therapeutic laboratory, nursing home, health service or any healthcare service to which you refer your patients? ☐Yes ☐No

If yes, please specify and fully explain._____

IV. PRIOR COVERAGE HISTORY

17. a. Do you currently carry your own separate, professional liability policy? ☐Yes ☐No

If yes, please include a copy of that declarations page with the completed application form.

Name of present carrier: _____

Number of years: _____

If less than 5 years, please list previous carrier as well: _____

b. Type of policy (if known): ☐Occurrence ☐Claims-made

c. Limits of present coverage: _____/_____

If prior professional liability insurance was on a claims-made basis, indicate the retroactive date of the coverage:

(Date after which wrongful acts are covered.) _____ /_____ / _____

d. If you selected Claims-made in Question 12 b., please check the appropriate box below:

i. The Extended Reporting Period Endorsement has been purchased on my prior policy. ☐ Yes ☐ No
If yes, please indicate the name of prior carrier: _____

ii. Prior Acts Coverage is requested on my new Claims-made policy. ☐ Yes ☐ No

If yes, please indicate Retroactive Date desired: ___ / ___ / ____

(Please submit Declarations page for all individuals listed in Question 6.)

e. If you answered No to Questions 17 e. i. and ii., please review the statement and check the box below:

☐ I understand that I elected not to purchase the Extended Reporting Period Endorsement on my prior Claims-made policy, and I also have elected not to purchase the Prior Acts Coverage on my new Claims-made policy. I understand that I will be uninsured for the period in which my prior Claims-made policy existed. Furthermore, I understand that because of this there will be a gap in my insurance coverage.

VI. REPRESENTATIONS

18. a. Have you ever been convicted of a crime in any state or country? ☐ Yes ☐ No

If yes, please give full particulars in order for your Application to be considered. _____

_____

_____

b. Have you ever had any licensing board or professional ethics body require the surrender of a license or found you guilty of a violation of ethics codes, professional misconduct, unprofessional conduct incompetence or negligence in any state or country?

☐ Yes ☐ No

If yes, please give full particulars and provide copies of charges, correspondence and any findings in order for your Application to be considered._____

_____

_____

c. Are there any complaints, charges or investigations pending against you by a licensing board or professional ethics body for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence, or negligence in any state or country?

☐ Yes ☐ No

If yes, please give full particulars and copies of charges, correspondence and any findings in order for your Application to be considered._____

_____

d. Have you ever had any insurance company or Lloyd's decline, cancel, refuse to renew, or accept only on special terms any professional liability insurance?

☐Yes ☐No

NOTE: MISSOURI APPLICANTS DO NOT RESPOND TO QUESTION 18d.

If yes, please give full particulars in order for your Application to be considered._____

_____

e. Has any professional liability claim or suit ever been made against you?

☐Yes ☐No

If yes, please give full particulars and copies of any summons and complaints, pertinent correspondence and outcome, if any, in order for your Application to be considered.

_____

_____

f. Are there any circumstances, including any loss of private or confidential information, which you are aware of that may result in any professional liability claim or suit being made against you?

☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered._____

_____

g. Have you engaged in or ever been engaged in any sexual misconduct* with any of your current or former patients or any current or former patient's spouse or any person with a direct relationship to the current or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)?

☐Yes ☐No

(*"Sexual misconduct" means any actual or alleged erotic physical contact or attempt, threat or proposal thereof.)

If yes, please give full particulars in order for your Application to be considered.

_____

_____

h. Have you ever had any hospital restrict or revoke privileges or invoke probation for any cause?

☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered.

_____

_____

i. Have you ever been suspended, restricted, or put on probation by any governmental health program (i.e. Medicare or Medicaid)?

☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered.

_____

_____

j. Are you now being, or have you ever been, treated for a serious health problem that did or can impair your ability to treat patients?

☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered.

_____

VII. NOTICES TO APPLICANT & FRAUD WARNINGS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

INSURANCE POLICIES ARE SUBJECT TO A 45 DAY UNDERWRITING PERIOD BEGINNING ON THE EFFECTIVE DATE OF COVERAGE. IF THE INSURER DISCOVERS A MATERIAL RISK FACTOR DURING THIS PERIOD, THEN THE INSURER SHALL RECALCULATE THE PREMIUM PROVIDED THE RISK CONTINUES TO MEET ITS UNDERWRITING STANDARDS AND NOTICE OF THE RECALCULATED PREMIUM SHALL BE SENT TO THE INSURED. THE INSURER MAY CANCEL THE POLICY IF THE RISK DOES NOT CONTINUE TO MEET ITS UNDERWRITING STANDARDS, IN WHICH CASE NOTICE OF CANCELLATION SHALL BE SENT TO THE INSURED AT LEAST 15 DAYS PRIOR TO CANCELLATION.

VIII. DECLARATION AND SIGNATURE

I understand that is it my obligation to maintain any license required in the jurisdictions in which I practice.

Date:_____ Signature:_____
(This application must be dated within 30 days of receipt) (APPLICANT / OWNER / PRESIDENT OF CORPORATION)

Title:_____

Application must be signed, dated, fully completed and accompanied by the premium to be considered.

Please make checks payable and mail to: American Professional Agency, Inc.

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694
www.americanprofessional.com

Producer Signature:

Save form first on your computer before submitting.

ADDENDUM TO APPLICATION

Name of Applicant: _____

If you have answered YES to Question #12a of the application, please complete the following questions:

1. Please list the institution(s) and indicate the hours you practice at each:

Institution Name	Number of Hours

2. Please describe the nature of work done at each facility:

_____

_____

_____

3. Are you doing in-patient work? _____Yes _____No
   If yes, are you treating your own patients or the facility's patients?

   _____

   If they are the facility's patients and they are assigned to you, are you the only treating psychiatrist while they are at the facility? _____Yes _____No
   If no, please explain_____

   _____

Please note: If the facility covers you for your work, it will be excluded from coverage. If you are not covered by the facility, it is possible that a debit may be applied to cover you for the additional exposure you have. This would apply especially in the case where you are not the only treating psychiatrist for the patients to whom you are assigned.

American Professional Agency, Inc.
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CLAIM ACTIVITY

Be sure to answer all question fully, leave no blanks.

a) Name of claimant or plaintiff:_____
(Last) (first) (Middle)

Age:_____ Sex:_____ Marital Status:_____

b) Date of alleged incident:_____

c) Location of incident (Hospital, office, clinic, etc.) :_____

d) Issue or type of injury claimed: - What was the objective issue contested in this claim ?

Injury: ☐ Emotional Only ☐ Cosmetic ☐ Temporary Disability ☐ Permanent Disability ☐ Death

Diagnosis:_____

Prognosis:_____

Prior Treating Physicians:_____

Subsequent Treating Physicians:_____

_____

e) Were other physicians or hospitals involved as co-defendants ? ☐ No ☐ Yes Please list names: _____

_____

f) Name of insurance company defending you: _____

g) Was claim or suit: ☐ actually brought against you ☐ merely threatened, or ☐ limited to claimants attorney contact?

h) Disposition of claim:

☐ Abandoned (no activity over 3 years)

☐ Won by defense

☐ Judgement or verdict vs. co-defendant(s) only

☐ Settled ☐ won by claimant. If so, how much was paid on your behalf? _____

_____

☐ Open (State Current Status) _____

Narrative Description of Incident _____

_____

_____

Please photocopy this form and supply us with separate information for each claim, suit or incident.
CAP-SUP (6/00)

QUARTERLY BILLING FORM

PLEASE READ THE FOLLOWING INFORMATION CONCERNING OUR QUARTERLY BILLING PROCEDURE

The following procedures will apply for accounts with premium exceeding $1,000 annually, that wish to pay in quarterly installments:

1. A bill will be issued to you 45 days prior to the due date for each quarterly payment.

2. Since we are required to give you advanced notice that your coverage will lapse if payment is not received, a notice will be sent stating that if payment is not received your policy will be cancelled on the date indicated on the cancellation notice. This is required state insurance regulations and also serves as a reminder that payment has not been received.

3. If a notice of cancellation is sent out and payment is then received prior to the cancellation date, a letter voiding out the cancellation will be provided to you.

I wish to make my payments in installments. I have remitted 35% of the annual premium.

I understand that I will be billed for the remaining quarters and a $5.00 service charge will be included in each quarterly bill. A $20.00 service charge will be assessed to each quarterly payment which is returned for uncollected funds.

E-mail address: _____

Signature: _____ Date:_____

IMPORTANT SURCHARGE INFORMATION
Allied World Insurance Company

NOTICE TO FLORIDA RESIDENTS:

The Florida Insurance Guaranty Association requires insurance companies to charge all policies written for its residents a surcharge of 1%. Please include this additional premium when remitting your premium.

NOTICE TO KENTUCKY RESIDENTS:

Kentucky law requires insurance companies to charge all policies written for its residents a surcharge of 1.8%. Depending on your profession, we may be required to assess your policy with a municipality tax which is based on the location of your residence. Please include this additional premium when remitting your premium.

NOTICE TO MAINE RESIDENTS:

The Rural Medical Access Program requires insurance companies to charge physicians, hospitals, and physicians' employers who are insured for professional liability through a licensed insurer to pay the assessment of .4% to the insurer upon the insurers' premium billing. This charge applies to policyholders who are Psychiatrists, Psychiatric NPs, Physician Assistants, Neurologists, Nurse Practitioners, APRNs, and CNSs with prescriptive authority.

NOTICE TO NEW JERSEY RESIDENTS:

The New Jersey Property and Liability Insurance Guaranty Association requires insurance companies to charge all policies written for its residents a surcharge of .3%. Please include this additional premium when remitting your premium.

NOTICE TO WEST VIRGINIA RESIDENTS:

West Virginia law requires insurance companies to charge all policies written for its residents a surcharge of .55%. Please include this additional premium when remitting your premium.