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

ALLIED WORLD
A FAIRFAX Company

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 SOCIAL WORKERS' 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.

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: _____ License No.:_____
Date of Birth: _____ E-mail address: _____
Office Telephone: ( ) _____ Home Telephone: ( ) _____

Fax Number: ( ) _____

(b) Coverage desired (check one):

☐Individual ☐Partnership ☐Professional Corporation (Incorporated as a P.C. or P.A.) ☐LLC/LLP
☐General Business Corporation: ☐Profit ☐Nonprofit ☐Other (Please explain) _____

(If you are unsure of your corporate status, please check your Articles of Incorporation or other business documents.)

If you have checked anything other than "Individual" above, the following MUST BE INCLUDED: (1) a copy of articles of incorporation; (2) a letter describing all services provided; (3) any brochures if available; and (4) a listing of owners and/or partners, indicating the percentage of the business owned by each.

II. APPLICANT INFORMATION

HAVE ANY OF YOUR RESPONSES TO QUESTIONS 2 OR 3 BELOW CHANGED SINCE THE COMPLETION OF YOUR LAST APPLICATION WITH THE INSURER FOR THIS COVERAGE? IF YES, PLEASE RESPOND TO THOSE QUESTIONS WITH YOUR CHANGES. IF NOT, PLEASE SKIP TO SECTION III.

2. Mailing Address:_____

_____
(City) (County) (State) (Zip code)

3. (a) Policy Limits Requested (check one option):

☐ $1,000,000/1,000,000 ☐ $1,000,000/3,000,000 ☐ $1,000,000/4,000,000 ☐ $1,000,000/5,000,000

The first Limit of Liability is applicable to each claim. All claims arising from a wrongful act, or a series of continuous, repeated or related wrongful acts, are treated as one claim. The second limit is the annual aggregate for all claims, which is the most the Insurer is liable for.

(b) Are you interested in obtaining limits higher than $35,000 for defense expenses related to licensing board investigations and other proceedings as described in the Policy? ☐ Yes ☐ No

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

☐ $50,000 ☐ $75,000 ☐ $100,000

☐ $125,000 ☐ $150,000

(c) Have you ever had a request to increase your limits of liability for defense expenses for proceedings declined?
☐ Yes ☐ No If yes, please explain: _____

III. PRACTICE CHARACTERISTICS

HAVE ANY OF YOUR RESPONSES TO QUESTIONS 4 THROUGH 12 BELOW CHANGED SINCE THE COMPLETION OF YOUR LAST APPLICATION WITH THE INSURER FOR THIS COVERAGE? IF YES, PLEASE RESPOND TO THOSE QUESTIONS WITH YOUR CHANGES. IF NOT, PLEASE SKIP TO SECTION IV.

4. List your name and qualifications. In addition, list the names and qualifications of all your salaried (W2) employees, except clerical. If you are applying for a partnership policy, please list all partners as well. Please use a separate sheet of paper if additional space is required. Please include the premium charge indicated on the rate schedule for yourself and each employee and/or partner.

Name	Degree	Field of Study	Date Degree Received (mm/dd/yy)	*Number of hours practice each week	License or Certification			
					First Year Licensed/Cert	State	Title	License Number

To qualify for the New Graduate Discount, we need the exact date you received your degree (must be within two years) and a statement indicating this is the first time practicing professionally.

*You must include all hours you practice (privately and as an employee). If your total hours exceed 20, you do not qualify for the part-time rate.

5. If your highest degree is a BSW, or if you are a new graduate or first-time practitioner, the following information must be included with your application and payment for review of acceptability.
   (a) The name of your supervisor:_____
   (b) Supervisor's degree, field of study, license and/or certification:_____
   (Supervision must be provided by a professional with a minimum of a Master's Degree in the mental health/social workfield.)

6. Please list the number of your entire employed staff (except clerical) including yourself. _____
   Note: Your staff is defined as your direct employees (for whom you file a W-2 form) and their names and credentials must be included with yours under Question 4. to correspond with the number listed here.

7. Is the applicant a member in good standing of any professional association? ☐ Yes ☐ No
   (a) If so, state the organization and type of membership.
   (i.e. Regular, Clinical, Associate, Student, etc.):_____

8. Are you engaged in self-employment, paid consultation (1099 form), private practice or volunteer work?
   ☐ Yes ☐ No

9. Are you employed (a W-2 form employee)? ☐ Yes ☐ No
   If yes, on a full-time or part-time(20 hours or less) basis? ☐ Full-Time ☐ Part-Time
   If yes, please complete the information below.

   (a) Name of your employer:_____
   (b) Address of your employer: _____

   If you are <u>both</u> self-employed and a W-2 employee, and wish to apply for part-time self-employed coverage, a separate statement indicating that you are fully insured by your employer at your W-2 employment must be submitted.

   ☐ ***I understand that if I apply and qualify for the exclusively employed rate, the policy will exclude coverage for private practice, self-employment, consulting, volunteering or social work outside of the course and scope of my employment.***

10. Do you or any person named in Question 4. own, partly own, manage or exercise any form of fiduciary control over any business enterprise that provides social work or mental health services? ☐ Yes ☐ No
    If yes, please explain, and include the name of the business or enterprise:_____

11. (a) Does the Applicant use any Independent Contractors or Consultants (1099 form) whose services are in the mental health field and who you do billing for, share fees with or in any way derive income from the relationship? ☐ Yes ☐ No
    (b) If yes, please list the name and professional credentials of each one.

All Independent Contractors or Consultants (1099 form) must be listed and the premium shown on the rate schedule included. **You will be covered for their acts subject to the terms of the policy, but the independent contractors or consultants listed will not be insureds under the policy.**

Name of Independent Contractor or Consultant	Degree	Field of Study	License or Certification State	Title

If additional space is required, please use a separate sheet of paper to submit a complete listing.

12. Has any person or entity, based on a contractual obligation requested that they be added to your policy as an Additional Insured?
    ☐ Yes ☐ No

    (a) Name of proposed Additional Insured: _____

    (b) Address of proposed Additional Insured: _____

    (c) The Additional Insured is my:
    ☐Employer ☐Landlord ☐Professional Corporation ☐Other (Specify): _____

    (d) The Additional Insured gives me the following form to file with the IRS:
    ☐W-2 form ☐ 1099 form ☐Other (Specify): _____

    (e) Describe the relationship between you and the Proposed Additional Insured: _____

    (f) Are you requesting that the person or entity named in 12(a) above be added as an Additional Insured in order to fulfill a contractual obligation? ☐ Yes ☐ No

    If yes, provide full particulars: _____

IV. REPRESENTATIONS

ALL RENEWAL APPLICANTS MUST COMPLETE THIS SECTION.

13. After inquiry* of each individual listed in Question 4:

***** "After inquiry" means that the Applicant has inquired of each person as to whether he/she has information pertinent to this question.

If you answer "Yes" to any question below, please include all documents pertinent to the situation you are describing.

(a) Has any person named in Question 4, including yourself, 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) Has any person named in Question 4, including yourself, ever had any licensing board or professional ethics body require the surrender of a license or found any such person or 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 any person named in Question 4, including yourself, 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) Has any person named in Question 4, including yourself, 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

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 any person named in Question 4, including yourself, their predecessors in business or against any past or present partner(s)? ☐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, of which any person named in Question 4, including yourself, is aware of that may result in any professional liability claim or suit being made against any person named in Question 4, including yourself, their predecessors in business or against any past or present partner(s)? ☐Yes ☐No

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

(g) Is any person named in Question 4, including yourself, 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) Are you now being or have you ever been treated for a serious health problem that did or can impair your ability to treat clients?
☐Yes ☐No

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

V. 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 any quotation or agreement to bind insurance.

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

VI. 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.


Producer Signature:

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

Save form first on your computer before submitting.

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.