



PROFESSIONAL LIABILITY ASSOCIATION, INC.
RISK RETENTION GROUP, INC.

ALLIED MEDICAL PROFESSIONAL LIABILITY APPLICATION

APPLICANT'S INFORMATION:

APPLICANT NAME:			
MAILING ADDRESS:			
COUNTY:		DATE ESTABLISHED:	
CONTACT PERSON:		PHONE NUMBER:	
DESIRED EFF DATE:		RETRO DATE:	
DESIRED LIMITS OF LIABILITY:			
Type of Enterprise:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> Non-Profit <input type="checkbox"/> For Profit <input type="checkbox"/> Other _____		
Affiliated Subsidiaries:	_____		
Estimated receipts/operating budget for the next 12 months:			
Estimated payroll for the next 12 months:			
Full description of services rendered:			

Current Insurance:

Has applicant had previous insurance for this enterprise? Yes
If yes, complete the following: No

<i>General Liability</i>		<i>Professional Liability</i>	
Current Carrier		Current Carrier	
Policy Term		Policy Term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you?
 Yes
 No
If yes, complete the following:

Date of loss:	
Current reserve or amt paid	
Description of loss	
Date of loss:	
Current reserve or amt paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been made aware of any circumstances, which may result in a claim? Yes
 No
If yes, provide full details.

Has any license or accreditation ever been suspended, denied or revoked? Yes
 No

Of what professional association(s) is Insured a member in good standing? _____

STAFF:	FULL TIME:	PART TIME:	CONTRACTED/EMPLOYED:
Administrators			
MD/Physicians			
Nurses			
Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or Volunteers			
Others (Specify)			

Check the hiring procedures that apply or are performed by this operation.

Criminal Background Checks Reference Checks

Questioning of employees in their previous involvement as defendants in professional malpractice litigation

Verification of certification or professional licensing.

Drug, alcohol and sexual abuse screening or testing

Schedule of Physicians - on Staff or Contracted:					
Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance (Yes or No)

Do you wish physician to be covered under the Center's policy? Yes
 No

Are any drugs or medication administered or prescribed? Yes
 No

If yes, explain:

Is electroshock therapy utilized? Yes
 No

Is yes, how many per year?

Schedule of Location: If more than 3 locations, attach a separate sheet of locations	
#1 Address	
Type of Services Provided	
#2 Address	
Type of Services Provided	
#3 Address	
Type of Services Provided	

Services Provided:			
<i>Please indicate the Number of Beds</i>			
Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Detox.		Independent Living	
Halfway House		Foster Care (children)	
Apartments		Other (specify)	
<i>Please indicate the Number of annual Outpatient or Client Visits</i>			
Alcohol/Drug Rehab		Counseling	
Mental Health		Methadone	
<i>Please indicate the Number of Clients per day</i>			
Adult Day Care		Partial Hospitalization	
Child Day Care		Sheltered Workshops	
<i>Please indicate the Number of Calls (annually)</i>			
Hotline		Information	
Transport - Emergency		Non-emergency	
Referral		Other (specify):	
<i>Please indicate the Annual Employee Assistance Programs (EAP) contracts or visits</i>			
Assessments		Counseling Visits	
Referrals		# of co.'s under contract	
<i>Please indicate the Number of Home Health Care Visits</i>			
Nonprofessional hours		IV Therapy	
Professional hours		Other (specify):	

If the limit of liability under your prior claims-made policy was less than that for which you are applying for hereunder, the lower limit applies. If the limit of the policy is lower than the limit that you carried previously, then the lower limit applies.

Please understand that there may be differences in coverage between that provided by your previous carrier(s) and the coverage applied for hereunder. Only those items covered under the Policy will be covered under a prior acts endorsement.

I declare that I know of no potential or actual claims, suits or incidents presently pending which have not been reported to my previous carrier(s). I understand that "Carrier" also means "Insurer"

I understand that this is only an application for Prior Acts Coverage and not a guarantee of coverage. **UNDER NO CONDITION WILL PRIOR ACTS BE COVERED WITHOUT THE RETURN OF THIS APPLICATION AND A PROPERLY EXECUTED ENDORSEMENT.**

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT IF PRIOR ACTS COVERAGE IS OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION, IT IS VOID.

Applicant's Signature: _____

Title: _____

Date: _____