ALLIED MEDICAL COUNSELORS & COUNSELING SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Are you in private practice?  □ No □ Yes
   Please indicate the (%) percent of time spent in the following work locations:
   Administrative Office _____  Patient’s Home _____  Professional Office _____
   Classroom _____  Outpatient Clinic _____  Laboratory _____
   Operating Room _____  Nursing Home _____  Emergency Dept. _____
   Hospital Ward (specify) _____  Other (specify) _____  of a Hospital _____

2. If services performed are counseling, indicate the (%) percent of total counseling:
   Family Planning _____  Drug Methadone _____  Legal _____  Crisis Intervention _____
   Marital _____  Alcohol _____  Criminal _____  Adoption Screening _____
   Family _____  Narcotics _____  V.D. _____  Foster Care Screening _____
   Abortion _____  Domestic Abuses _____  Pastoral _____  Other (specify) _____

3. Please provide the percentage of counseling work performed for each of the following age brackets
   (should equal 100%): Ages:  0-12 _______  13-18 _______  19-34 _______  35 and up _______

4. Please answer the following:
   a. Are you a religiously affiliated or pastoral counselor?  □ No □ Yes
   b. Number of families in church?  □ No □ Yes
   c. Is there a charge for counseling services?  □ No □ Yes
   d. Are counseling sessions kept strictly confidential?  □ No □ Yes
   e. If “No,” explain:
   f. Any youth group activities?  □ No □ Yes
   g. Any overnight activities?  □ No □ Yes
   h. If “Yes,” please describe:
   i. Who supervises?
   j. How many supervisors?
   k. Day Care?  □ No □ Yes
      If “Yes,” number of children, number of staff, hours of operation:

5.  EMPLOYEES  NUMBER OF FULL TIME  NUMBER OF PART TIME
   Administrators*
   Counselors*
   Psychologists
   Nurses, RN
   Nurses, LPN
   *Indicate Total with Masters

   DEGREE  FULL TIME  PART TIME
   Home Health Aids
   Social Workers
   Clerical
   Teachers
   Physicians
   Minister/Priest/Rabbi
   Psychiatrists
6. Estimated number of outpatient visits in the next 12 months: 
   Estimated number of outpatient visits in the previous 12 months: 
   Estimated number of Hot Line Calls in the previous 12 months: 

7. Is applicant engaged in, associated with, or involved in any other enterprise?  
   Yes ☐ No ☐  
   If "Yes," provide details: 

8. List any professional association in which applicant is a member: 

9. Describe any professional training, licensing or certification needed for this operation: 

10. Is anyone applying for insurance under this policy aware of any circumstances involving sex with any patients, former patients or relatives thereof?  
    Yes ☐ No ☐  
    If "Yes," please explain: 

11. Does anyone applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate?  
    Yes ☐ No ☐  
    If "Yes," please explain: 

12. Does anyone applying for insurance under this policy use any form of recovered or repressed memory therapy?  
    Yes ☐ No ☐  
    If "Yes," please explain: 

13. Does anyone applying for insurance under this policy testify or consult in child abuse litigation (civil or criminal)?  
    Yes ☐ No ☐  
    If "Yes," please explain: 

14. Do you administer any anesthesia?  
    Yes ☐ No ☐  
    If "Yes," please explain: 

15. Do you prescribe medications?  
    Yes ☐ No ☐  
    If "Yes," please explain: 

16. If you contract your services to others on an independent contractor basis, advise who you contract your work to: 

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.  
* not applicable in all states 

DECLARATION AND SIGNATURE: 
The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application. 

Applicant’s Signature ________________________________ Sub-Producer ________________________________ 
Title/Date ________________________________ Producer ________________________________

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.
ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Desired Effective Date:__________________________________________

2. Applicant Name:________________________________________________

3. Mailing Address:________________________________________________

4. City, State, Zip:________________________________________________

5. County:________________________________________________________

6. Telephone Number:____________________________________________

7. Inspection Contact:_____________________________________________

8. Website Address:_______________________________________________

9. Date Established:_______________________________________________

10. Years in Business Under Current Management:_____________________

11. Type of Enterprise: □ Corporation □ Individual □ Partnership □ Joint Venture
    □ Municipality □ In-Patient -Psychiatric □ Other (describe):____________

12. Enterprise is: □ For Profit □ Not For Profit

13. Estimated receipts/operating budget for the next twelve (12) months:________

14. Estimated payroll for the next twelve (12) months:____________________

15. Type of Operation: □ Mental Health Inpatient □ Group Home (Non-Elderly)
    □ Prison/Jail □ Boot Camp □ Lock-down Facility □ Shelters/Halfway House
    □ Alcohol/Drug Detox. □ Alcohol/Drug Inpatient □ Apartments □ Foster Care (children)
    □ Independent Living (Elderly) □ Assisted Living Facility □ Other (describe):____________

16. Full description of services rendered: ________________________________
    _______________________________________________________________
    _______________________________________________________________

II. CURRENT INSURANCE

This section must be completed for prior acts consideration. Attach a copy of expiring policy declarations page.

1. a. Has Applicant had previous insurance for this enterprise? □ Yes □ No

   b. If Yes, complete the following for prior three (3) years of general/professional liability coverage:

<table>
<thead>
<tr>
<th>Name of Carrier</th>
<th>Effective Date</th>
<th>Expiration Date</th>
<th>Limit</th>
<th>Deductible</th>
<th>Premium</th>
<th>Claims Made (CM) or Occurrence?</th>
<th>CM Retroactive Date</th>
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III. CLAIMS ACTIVITY AND INCIDENT REPORTING PROCEDURES

1. Claims and Incident Activity

   **Important Notice:** All known claims and/or incidents that could reasonably result in a claim are specifically excluded from coverage. Report all such claims or incidents to your current insurer. Your failure to disclose any claim, or incident that could reasonably result in a claim, may result in the proposed insurance being void and/or subject to rescission.

   a. Claims Activity - Please list all claims that have been presented to you or to your past or your current insurer during the past five years. Please continue on a separate sheet of paper if necessary.

<table>
<thead>
<tr>
<th>Date of Loss</th>
<th>Current Reserve or Paid Amount</th>
<th>Description of Loss</th>
<th>Insurer</th>
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<tbody>
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</tbody>
</table>

   b. Incident Activity - Please outline the details below regarding any of the following incidents that have taken place at any of your facilities for which coverage is being requested, but where such incidents have not been reported to any insurer:

      Death of a client, patient or resident from other than natural causes;
      Injury to a client, patient or resident that required hospitalization;
      Incident involving abuse, molestation, sexual assault, rape or improper contact;
      Incident that generated a formal complaint or notice from any federal or state regulatory body;
      Injury resulting from an elopement or unauthorized absence of a client, patient or resident;
      Improper medication or improper dosage resulting in hospitalization; or
      Decubitus ulcer(s) first acquired under your care that have reached Stage IV.

   ____________________________________________
   ____________________________________________
   ____________________________________________

   1) Are there any other known incidents that could reasonably be expected to result in a claim against the Applicant? □ Yes □ No
   2) Have all known incidents that could reasonably be expected to result in a claim been reported to your current or prior insurer? □ Yes □ No

2. Risk Management Protocols

   a. Are there procedures in place requiring the documentation of all incidents in a written report? □ Yes □ No

   b. Who is responsible for receiving and recording information relating to incidents and reporting them to your insurer?

      Name: ___________________________________________________________ Title: ____________________________
3. Other
   a. Has any license or accreditation ever been suspended, denied or revoked? □ Yes □ No
   b. Please list all professional association(s) in which the Applicant is a member in good standing:
   
   c. Has the Applicant ever had its professional liability insurance policy cancelled or non-renewed? □ Yes □ No
   d. If Yes, please explain:

   ________________________________________________________________________________

IV. OPERATIONS

1. Indicate current staffing levels:

<table>
<thead>
<tr>
<th>Staff</th>
<th>Employed Full Time</th>
<th>Employed Part Time</th>
<th>Contracted Full Time</th>
<th>Contracted Part Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrators</td>
<td></td>
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<tr>
<td>MD/Physicians</td>
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<tr>
<td>Nurses</td>
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<tr>
<td>Homemakers/Nurse Aids</td>
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<tr>
<td>Psychologists</td>
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<td>Counselors</td>
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<tr>
<td>Therapists</td>
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<tr>
<td>Students or volunteers</td>
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<tr>
<td>Other (describe):</td>
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</tbody>
</table>

2. Check the hiring procedures that apply or are performed by this operation:
   □ Criminal Background Checks   □ Verification of certification or professional licensing
   □ Drug, alcohol and sexual abuse screening or testing   □ Reference Checks
   □ Questioning of employees in their previous involvement as defendants in professional malpractice litigation

3. Schedule of Physicians – on Staff or Contracted:

<table>
<thead>
<tr>
<th>Name &amp; Specialty</th>
<th>Board Certified</th>
<th>Board Eligible</th>
<th>Hours/Week Worked</th>
<th>Volunteer, Contracted or Employed</th>
<th>Has Malpractice Insurance</th>
</tr>
</thead>
<tbody>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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</tbody>
</table>

4. List the duties of the physician(s) in 3. above: __________________________________________________________

5. Do you want any listed physician to be covered under the facility’s policy? □ Yes □ No

6. a. Are any drugs or medications administered or prescribed? □ Yes □ No
    b. If Yes, please explain: __________________________________________________________

   ________________________________________________________________________________
V. LOCATION INFORMATION

1. Schedule of Locations: If more than five locations, please attach a separate sheet of locations.

<table>
<thead>
<tr>
<th>Address</th>
<th>Types of Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1</td>
<td></td>
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<tr>
<td># 2</td>
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<td># 3</td>
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<td># 4</td>
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<tr>
<td># 5</td>
<td></td>
</tr>
</tbody>
</table>

2. a. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? □ Yes □ No
   b. If Yes, please submit brochure or describe activities: ____________________________________________

3. a. Are there any firearms on the premises? □ Yes □ No
   b. If Yes, please describe: ____________________________________________
   c. Are the firearms locked in a secure place away from the residents? □ Yes □ No
   d. If No, please describe: ____________________________________________

4. a. Are there any animal exposures on the premises? □ Yes □ No
   b. If Yes, are the animal exposures: □ Owned? □ Non-owned?
   c. If Yes, please describe, including number of animals and type/breed: ____________________________________________

5. a. Are there any lakes, ponds, rivers, pools or other bodies of water on the premises? □ Yes □ No
   b. If Yes, please describe: ____________________________________________
   c. Are there any swimming or boating activities? □ Yes □ No
   d. If there is a pool or body of water, then is it fenced with a self-locking gate? □ Yes □ No
   e. If there is a pool or body of water, then is there a diving board and/or slide? □ Yes □ No

VI. COVERAGE REQUESTED

1. Complete and attach the appropriate supplemental application with your submission.

2. Check the coverages and limits that the Applicant would like quoted:
   a. Coverages: □ GL □ Professional □ Excess (Attach Acord App)
   b. Limits: □ $100,000/$100,000 □ $300,000/$300,000 □ $500,000/$500,000
      □ $1,000,000/$1,000,000 □ $1,000,000/$2,000,000 □ $1,000,000/$3,000,000

3. a. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? □ Yes □ No
   b. If Yes, at what limits? □ $25,000/$50,000 □ $50,000/$100,000 □ $100,000/$300,000
      □ $250,000/$250,000 □ $500,000/$500,000 □ Other: ______
Please attach a copy of the following with your submission:

Five (5) years of currently dated loss runs (if in business less than five (5) years, please attach a resume of the owner/director)

Brochure(s) available or other information pertaining to the programs offered

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

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**WARRANTY STATEMENT AND SIGNATURE:**

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

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Authorized Signature on behalf of Applicant ____________________________

Sub-Producer

Title/Date ___________________________________________________________

Producer

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SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.