ARGO PRO
Member Argo Group

BSR
PO Box 768 · Hendersonville, TN 37075
(T) 800-768-7475 · (F) 615-264-3980
www.bsrins.com

ALLIED MEDICAL PSYCHIATRIST SUPPLEMENTAL APPLICATION

A. GENERAL INFORMATION:

1. Name of Clinic/Center: _____
2. Do you serve as the Medical Director or Chief of Psychiatry at this location? ☐ Yes ☐ No
3. Do you teach at this location? ☐ Yes ☐ No

B. PROFESSIONAL TRAINING:

1. List the professional societies of which you are a member: _____

   _____
2. License Number(s) and State(s): _____
3. Medical School Attended: _____ Country: _____

   Year Graduated: _____ Degree: _____
4. If you are a graduate of a non-US medical school, have you obtained an ECFMG Certificate? ☐ Yes ☐ No
5. Are you Board Certified in any of the following specialties?

Yes	No	Specialty	Date Attained (mm/dd/yy)
☐	☐	General Psychiatry	
☐	☐	Child & Adolescent Psychiatry	
☐	☐	Geriatric Psychiatry	
☐	☐	Administrative Psychiatry	
☐	☐	Other (Specify):	

6. a. How many hours per week do you spend in active practice for Clinic/Center? _____

   b. How many weeks per year do you spend in active practice for Clinic/Center? _____
7. a. Have you successfully completed psychoanalytic training? ☐ Yes ☐ No

   b. If Yes: Date attained: _____

   c. Average weekly # of total practice hours: _____

   d. Average weekly # of psychoanalytical hours: _____

C. PRACTICE PROFILE: Please attach a separate sheet for any required explanations.

1. a. Do you sign insurance or other reimbursement forms for patients where you have not participated in their care and treatment? ☐ Yes ☐ No

   b. If Yes, please describe in what capacity (e.g., as a Medical Director) and indicate if you clarify what your signature means on such forms. _____

   _____

2. a. Do you create and maintain a psychiatric/medical record for each patient under your care? ☐ Yes ☐ No

   b. If No, please explain: _____

3. Do you prescribe controlled substances? ☐ Yes ☐ No

4. Do you obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics? ☐ Yes ☐ No

5. a. Do you write prescriptions for patients you have not clinically evaluated other than to cover for another colleague whose patient requires a minimal refill on an existing prescription? ☐ Yes ☐ No

   b. If Yes, please explain under what circumstances: _____

6. a. Do you treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment? ☐ Yes ☐ No

   b. If Yes, please describe: _____

7. a. Do you perform electro-convulsive therapy for the center named above (ECT)? ☐ Yes ☐ No

   b. Where is this procedure performed? _____

   c, Is Anesthesia always administered in a licensed Medical facility? ☐ Yes ☐ No

   d. Who administers Anesthesia?
   ☐ Anesthesiologist ☐ CRNA ☐ Other: (explain): _____

D. CLAIM INFORMATION

1. Have you ever been:

   a. The subject of an investigatory or disciplinary proceeding or reprimand? ☐ Yes ☐ No

   b. Have you been charged with, convicted of, or pleaded guilty or no contest to a felony? ☐ Yes ☐ No

   c. Treated for alcoholism or drug addiction? ☐ Yes ☐ No

2. Have you ever been, or are you currently, either sexually, romantically, or socially involved with any current, or former, patient or with a family member of a patient? ☐ Yes ☐ No

3. Have you ever had a settlement or judgment alleging undue familiarity, professional misconduct, or assault in connection with undue familiarity? ☐ Yes ☐ No

4. a. Have you ever had a malpractice claim or suit filed against you? ☐ Yes ☐ No

   b. If Yes, how many? _____

5. a. Do you know of any incident that may result in a claim against you? ☐ Yes ☐ No

   b. If Yes, for each claim, suit, or incident, complete a separate claim activity form.

E. INSURANCE

1. a. Has any insurance company ever declined, failed to renew, conditionally renewed or cancelled a Professional Liability Policy for you? ☐ Yes ☐ No

   b. If Yes, please list company, date, and reason for the action by the company: _____

2. a. Apart from the insurance provided by your employer, do you carry your own professional liability insurance? ☐ Yes ☐ No

   b. If Yes, what is the name of your insurer? _____

   c. Policy Number: _____

   d. Policy Dates: _____ Limits: _____

3. a. Is coverage: ☐ Occurrence ☐ Claims Made

   b. If Claims Made, what is retroactive date? _____

   c. Does this malpractice policy cover you for your acts at the center? ☐ Yes ☐ No

F. 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 COMPLETE THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.

COLONY SPECIALTY
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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:

Name of Carrier	Effective Date	Expiration Date	Limit	Deductible	Premium	Claims Made (CM) or Occurrence?	CM Retroactive Date

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.

Date of Loss	Current Reserve or Paid Amount	Description of Loss	Insurer

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:

Staff	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
Administrators				
MD/Physicians				
Nurses				
Homemakers/Nurse Aids				
Psychologists				
Counselors				
Therapists				
Students or volunteers				
Other (describe):_____				

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:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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.

	Address	Types of Services Provided
# 1		
# 2		
# 3		
# 4		
# 5		

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

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.

Authorized Signature on behalf of Applicant	Sub-Producer
Title/Date	Producer

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.