Darwin Professional Underwriters, Inc.
For:
Darwin National Assurance Company
Platte River Insurance Company

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

Application

for Mental Health Counselor's and Marriage and Family Therapist's Professional Liability Insurance

Offered through the Professional Counselors Purchasing Group, Inc.

Notice to Florida Applicants:
License # A127510 issued to Richard C. Imbert

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

Notice to Iowa Applicants:
License # IA0000000100776
issued to Richard C. Imbert

NOTICE: THIS IS A CLAIMS-MADE FORM: THE COVERAGE OF THIS POLICY IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE COMPANY DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.
NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE THE SPECIAL PROVISION "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.**

1.(a) Name of Applicant: ______________________________

Date of Birth: ______________________ Social Security No.: ______________________

(b) Coverage Desired (check one): E-mail address: ______________________

❏ 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.)

(c) **If you have checked anything other than individual the following MUST BE INCLUDED: a letter describing all services provided, include any brochures if available, as well as a copy of your articles of incorporation, and a listing of owners and/or partners, indicating the percentage owned by each.**

(COMPLETE QUESTION 2 ONLY IF YOU ARE CHANGING THE ADDRESS SHOWN ON YOUR BILL)

2. Change of Mailing Address: ______________________________ Bus. Phone #: ( )__________________
AREA CODE NUMBER

____

____
(CITY) (COUNTY) (STATE) (ZIP CODE)

3.(a) Limits of Liability desired (check one):
(Limits of Liability apply to each claim. A series of continuous, repeated or interrelated wrongful acts are considered one wrongful act and one claim.) The first limit is applicable to each claim. The second limit is the annual aggregate the insurer is liable for.
❏ $200,000/600,000 ❏ $500,000/1,000,000 ❏ $1,000,000/1,000,000 ❏ $1,000,000/3,000,000
❏ $1,000,000/4,000,000 ❏ $1,000,000/5,000,000 ❏ $2,000,000/2,000,000 ❏ $2,000,000/4,000,000

(b) Are you interested in obtaining limits higher than $5,000 for Defense Reimbursement (which is already included in your policy) for Licensing Board Hearings? ❏ Yes ❏ No
Limit of Liability desired for Defense Reimbursement for Licensing Board Hearings:
❏ $25,000 ❏ $50,000 ❏ $75,000

(c) Prior Acts Coverage? ❏ Yes ❏ No
Retroactive Date Desired __________________________(A copy of your Declarations page must be submitted)

4. (a) **Please check the correct box for your rating group. If you are applying for corporate or partnership coverage, please check the boxes that pertain to all professionals.**
❏ Group 1 - School Counselor
❏ Group 2 - Employed Counselor
❏ Group 3 - B.A. Level-Employed Counselor
❏ Group 4 - Clergy & Pastoral Counselor
❏ Group 5 - Self-Employed Counselor
❏ Group 5 - Certified Hypnotist
❏ Group 5 - Sex Counselor
❏ Group 7 - Psychoanalysts
❏ Group 8 - Employed Marriage and Family Therapist
❏ Group 9 - Self-Employed Marriage and Family Therapist

❏ I understand that if I qualify under Groups 1-3 or 8, the policy will exclude coverage for private practice.

NEW

Please complete the application on the next page.

Please complete every question fully.

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

Name	All Degrees you hold	Field of Study	I practice as a	*Number of hours of practice each week	License or Certification			
					First Year Licensed	State	Title	Number

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

(c) If your highest degree is a B.A. in the Mental Health Field, the following information must be included with your application and payment for review of acceptability.

1. Name and address of your employer: ______________________________

2. Tax form issued – 1099 or W2: ______________________________

3. The name of your supervisor: ______________________________

4. Supervisor's degree, field of study, license and/or certification: ______________________________

5.(a) 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 W2 form) and their names and credentials must be included with yours under Question 4 to correspond with the number listed here.

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

6.(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) If you are self-employed and fully covered as a W2 employee and wish to apply for the Part-time coverage the following must be submitted: a statement indicating that you are fully covered at your W2 employment.

7.Do you or any person named in Question 4 own, partly own, manage or exercise any form of fiduciary control over any business enterprise? ❑ Yes ❑ No
If yes, please explain: ______________________________

8.Has any person named in Question 4 ever had professional liability coverage? ❑ Yes ❑ No
If yes, please list:
Name of carrier: ____________________ Limits of Liability: ____________________

Premium: ____________________ Expiration Date: ______________ Retro Date: ______________

Policy Type: ❑ Claims-Made ❑ Occurrence Policy/Account #: ______________

If you checked off claims-made, please check the appropriate box below:

( ) I have purchased the extended reporting period endorsement on my prior policy.
Name of Carrier: ______________________________

( ) I have elected to take Prior Acts Coverage and completed Question 3(c) of this application. I realize that unless I purchase Prior Acts Coverage which coincides with the retroactive date of my previous claims-made policy and have no extended reporting period endorsement that I will have a gap in coverage.

( ) I understand that I elected not to purchase the Extended Reporting Period Endorsement on my previous claims-made policy. I understand that I will be uninsured for the period in which my prior claims-made policies existed. Furthermore, I understand that because of this there will be a gap in my insurance coverage.

9.(a) Does the applicant use any Independent Contractors or Consultants (1099 form) whose services are in the mental health field? ❑ Yes ❑ No
(b) If yes, please list the names and professional credentials of each one.

The Independent Contractor (1099 form) charge shown on the rate schedule must be included for each Contractor or Consultant listed and added to your premium. YOU WILL BE COVERED FOR THEIR ACTS SUBJECT TO THE TERMS OF THE POLICY BUT THE INDEPENDENT CONTRACTORS OR CONSULTANTS LISTED ARE NOT INSURED.

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.

Please complete the application on the next page.

Please complete every question fully.

REPRESENTATION SECTION

Any policy issued by the Company is based on the following Representations:

10.*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", 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.

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(b) Has any person named in Question 4, including yourself, ever had any licensing board or professional ethics body ever require you to surrender your 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 copies of charges, correspondence and any findings in order for your application to be considered.

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(c) Are there any complaints, charges or investigations pending against any person named in Question 4, including yourself, by any 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.

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(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?
NOTE: MISSOURI APPLICANTS DO NOT RESPOND ❑ Yes ❑ No

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

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(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.

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(f) Are there any circumstances 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, 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.

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(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 patient 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.

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SIGNATURES AND REPRESENTATIONS

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 Company in connection with this Application (together referred to as the "Application") are true and complete.

Please complete the application on the next page.

Please complete every question fully.

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

The Company is authorized to make any inquiry in connection with this Application. The Company's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Company 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 Company, and the Company may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA 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.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: 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, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: 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, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO WASHINGTON 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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

I UNDERSTAND THAT IT IS MY OBLIGATION TO MAINTAIN ANY LICENSE REQUIRED IN THE JURISDICTION(S) IN WHICH I PRACTICE.

Date: ______________________________ (This application must be dated within 30 days of receipt)

Signature: ______________________________ (APPLICANT/OWNER/PRESIDENT OF CORPORATION)

Title: ______________________________

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

Signature of Authorized Representative of the American Professional Agency, Inc.

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

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
P.O. Box 9009 • 95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

www.americanprofessional.com

PASTORAL COUNSELOR QUESTIONNAIRE

1. Are you an Ordained Minister?
   ____

2. What religion are you practicing? (ex. Catholic, Lutheran, etc.)
   ____

3. Where are you practicing? List all areas and specify if it is in the auspices of a church, etc.
   ____
   ____
   ____
   ____
   ____
   ____

4. What type of counseling do you practice and for what type of clientele?____________________
   ____
   ____
   ____
   ____
   ____

5. How do you title yourself? I practice as a ____
   ____

NAME____

ADDRESS____

CITY____________________________**STATE**_______________**ZIP**__________________

IMPORTANT INFORMATION
PURCHASING GROUP FEE NOTICE

A $5.00 annual Purchasing Group fee needs to be added to your premium to help defer the administrative costs for maintaining the Professional Counselors Purchasing Group.

Please make check payable to:

American Professional Agency, Inc.

Mail to:

American Professional Agency, Inc.
95 Broadway
Amityville, New York 11701