DARWIN NATIONAL ASSURANCE COMPANY

APPLICATION FOR PSYCHIATRIST PROFESSIONAL LIABILITY INSURANCE

Offered through the Professional Counselors Purchasing Group, Inc.

NOTICE:

THIS POLICY IS AN APPLICATION FOR CLAIMS MADE.

A LOWER LIMIT OF LIABILITY SHALL APPLY TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE THE SPECIAL PROVISION "SEXUAL MISCONDUCT" IN THE POLICY). PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR LEGAL OR INSURANCE ADVISOR.

DEFENSE EXPENSES SHALL BE PAYABLE IN ADDITION TO THE LIMITS OF LIABILITY, EXCEPT FOR PROCEEDINGS UNDER INSURING AGREEMENT I.B.

- ***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.:______________________

   E-mail address:______________________ License No.:______________________

   b. Type of Applicant (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.)

   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, and a listing of owners and/or partners, indicating the percentage owned by each.

   d. Do you request separate limits? ☐ Yes ☐ No

2 a. Principal Office Address: ____

   ____
   (City) (County) (State) (Zip)

   Note: If you have been practicing at this location fewer than 3 years, please provide us with your previous location on a separate sheet pf paper and the length of time at that location.

   b. Any Other Office Address: ____

   ____
   (City) (County) (State) (Zip)

   c. Home Address: ____

   ____
   (City) (County) (State) (Zip)

3. To which of these addresses do you wish correspondence sent? ☐ 2a ☐ 2b ☐ 2c

4. Office Telephone: ( ) ____________ Fax #: ( ) ____________ Home Telephone: ( ) ____________

5. a. Policy Limits Requested?____________ / ____________ (b) Effective date requested: ____________

   b. Are you interested in obtaining limits higher than $5,000 for defense costs related to licensing board investigations and other proceedings as described in the Policy? ☐ Yes ☐ No

   If yes, choose higher limit of liability desired for defense costs related to licensing board investigations and other proceedings as described in the Policy:
   ☐ $10,000 (Additional Premium $75) ☐ $25,000 (Additional Premium $95)
   Please include the additional premium indicated with your premium payment.

Please complete the application on the next page.

Please complete every question fully.

PRACTICE CHARACTERISTICS

6. a. 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.

Name	Degree	Field of Study	Professional Association Membership (list association and membership status)	Number of hours of practice each week	License or Certification			
					First Year Licensed	State	Title	Board Certified? Yes/No

b. **Please attach a copy of a Curriculum Vitae (C.V.) for each professional.**

7. PRACTICE PROFILE

a Does your practice include specialties? ☐ Yes ☐ No
If yes, please specify: ☐ Pediatrics ☐ General Practice ☐ Family Practice ☐ Other
If Other, please explain:____

b. Composition of your practice: Children/Adolescents/Related Adults_____% Prisoners_____%
Adults (not related to above)_____% Sex Offenders_____%

c. Do you have admitting privileges? ☐ Yes ☐ No
If no, please describe your mechanism for handling your patients who may require immediate in-patient care:
____

d. Do you create and maintain a psychiatric/medical record for each patient under your care? ☐ Yes ☐ No
If no, please explain:____

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

f. Do you provide medication management for patients who see another professional (e.g. Ph.D., MSW) as their primary therapist and see you for medication management only? ☐ Yes ☐ No
For how many patients per week?_______ Do you periodically see the patient yourself? ☐ Yes ☐ No
Do you have written protocols? ☐ Yes ☐ No

g. Do you regularly treat general medical conditions presented by your psychiatric patients? ☐ Yes ☐ No
If yes, please indicate: (1) Average number of patients per week you provide treatment to:_______
(2) Nature of the conditions you treat and the type of treatment you provide:____
____

h. Have you ever practiced a specialty other than psychiatry or neurology? ☐ Yes ☐ No
If yes, please specify:____

i. Do you advertise as a specialist* in the evaluation and treatment of any of the following? ☐ Yes ☐ No
☐ Borderline Personality Disorder ☐ Chronic Pain ☐ Multiple Personality Disorder or Dissociative Disorders ☐ Childhood Sexual Abuse ☐ Eating Disorder ☐ Sex Therapy

j. Do you supervise any other psychiatrist or other mental health care providers specializing in the disorders/activities listed in question "i"?
☐ Yes ☐ No

k. Does your treatment include use of abreaction, rage, sodium amytal, sex or recovered memory therapies? ☐ Yes ☐ No
If yes, please explain the clinical details regarding this treatment:____
____

l. Does your practice include forensic activities, e.g. child custody and visitation, criminal responsibility; competence, civil and criminal; correctional psychiatry; juvenile justice and violence? ☐ Yes ☐ No
What is the percent of your total practice time devoted to this activity?_____%
On a separate sheet, please explain the exact type of forensic activities.

m. Do you communicate with your patients via e-mail? ☐ Yes ☐ No. Please explain the nature of communications in detail.
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n. Does your practice include telemedicine activities, e.g. the transfer of data through electronic (video or computer) means in order to provide healthcare to patients who are geographically separated from the clinicians involved? ☐ Yes ☐ No What is the total practice time devoted to this activity? _____% On a separate sheet, please explain the exact type of telemedicine.

Application continued on the next page.

o. Do you engage in any clinical and/or pharmaceutical research? ☐ Yes ☐ No
If yes, does the sponsor agree in writing to indemnify you for such research activities?
If no, please explain type and extent of such activities:______________________________

p. Do you treat patients with unconventional therapy, i.e. treatment not considered to be mainstream psychiatric treatment? ☐ Yes ☐ No
If yes, please describe:______________________________

q. Do you cover any ER for crisis cover? ☐ Yes ☐ No
*Note: "Specialist" is indicated by 1) advertisements, 2) marketing materials, 3) letterhead, or 4) employment, contractual relationship or admitting privileges at any institution with a special interest in any of the above.

8. 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. Are you or any person named in Question 6(a) a salaried employee of any organization other than the applicant's firm or do you own, partly own, manage or exercise any form of fiduciary control over any business enterprise? ☐ Yes ☐ No
If yes, please explain:______________________________

9. Do you serve on a HMO, PPO or any other type of peer review board? ☐ Yes ☐ No
If yes, please describe:______________________________

10. a. Are you on the staff of, or affiliated with, any hospital, clinic or nursing home? ☐ Yes ☐ No
If yes, please list institution, nature of work and hours per week:______________________________

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b. Are you provided malpractice coverage by any of the above? ☐ Yes ☐ No
If yes, please indicate location and limits provided:______________________________

c. Do you have any direct or indirect financial interest in any hospital, pharmacy, diagnostic or therapeutic laboratory, nursing home, health service or any health care service to which you refer your patients? ☐ Yes ☐ No
If yes, please specify and fully explain.______________________________

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 included. 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.

PRIOR COVERAGE HISTORY

12. a. Name of present carrier:______________________________ Number of years:______________

If less than 5 years, please list prior carrier as well:______________________________

Type of policy (if known): ☐ Occurrence ☐ Claims-made

b. If prior professional liability insurance was on a claims-made basis, indicate the retroactive date of the coverage:
(Date after which wrongful acts are covered.)______________________________

c. Limits of prior coverage: ______________________________

d. 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:______________________________

Application continued on the next page.

☐ I elect to take Prior Acts Coverage. Retroactive Date desired: _____ / _____ / _____

☐ I understand that I elected not to purchase the Extended Reporting Period Endorsement on my previous Claims-made policy, and I also have elected not to purchase the Prior Acts Coverage on my new Claims-made policy. I understand that I will be uninsured for the period in which my prior Claims-made policy existed. Furthermore, I understand that because of this there will be a gap in my insurance coverage.

13. After inquiry of each individual listed in Question 6:
*"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 6, 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 6, 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 6, 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.

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d. Has any person named in Question 6, 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.

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e. Has any professional liability claim or suit ever been made against any person named in Question 6, 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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Application continued on the next page.

f. Are there any circumstances of which any person named in Question 6, including yourself, is aware of that may result in any professional liability claim or suit being made against any person named in Question 6, their predecessors in business or against any past or present partners(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 6, 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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h. Has any person named in Question 6, including yourself, ever had any hospital restrict or revoke privileges or invoke probation for any cause? ☐ Yes ☐ No

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

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i. Has any person named in Question 6, including yourself, ever been suspended, restricted, or put on probation by any governmental health program (i.e. Medicare or Medicaid)? ☐ Yes ☐ No

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

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j. Are you now being, or have you ever been, treated for alcoholism, narcotics addition or mental illness? ☐ Yes ☐ No

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

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Application continued on the next page.

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.

The information in this Application is material, if knowledge by the Company of any such information misrepresented would have lead to the Company's refusal to issue this Policy. 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.

I understand that it is my obligation to maintain any license required in the jurisdiction(s) in which I practice.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH THE 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 EACH SUCH VIOLATION.

Date:___________________________ Signature: ____
(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.

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
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