



Allied World Insurance Company ("Insurer")

All questions must be answered and the application must be dated and signed before a quotation is given.

Return and make checks payable to: American Professional Agency, Inc. 95 Broadway, Amityville, NY 11701 (631) 691-6400 • (800) 421-6694

LOUISIANA GENERAL LIABILITY SUPPLEMENTAL APPLICATION FOR SOCIAL SERVICE AGENCY PROFESSIONAL LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

This application will only be considered valid if submitted with a completed and signed general Application.

APPLICANT INFORMATION

Applicant Name: \_\_\_\_\_

REQUESTED COVERAGE

General Liability:  Occurrence  Claims-Made

Effective Date: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_

GENERAL LIABILITY EXPOSURE

Please complete the following table for each building or facility. Please attach a separate sheet if necessary.

Table with 7 columns: Location, Area, Age, Construction Type, # of Floors, Type of Fire Protection (City, State), Owned or Leased?. Rows include Patient Care Buildings and Other Buildings.

INSURANCE INFORMATION

Please provide the following information for General Liability Insurance for the current policy year and previous four years.

Table with 7 columns: Policy Period, Carrier, Limits, Deductible or SIR, Claims Made or Occurrence, Retro Date, Premium.

1.

**NOTICES TO APPLICANT & FRAUD WARNING**

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

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

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

**NOTICE TO LOUISIANA 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 FINES AND CONFINEMENT IN PRISON."

**APPLICANT SIGNATURE**

*I hereby acknowledge that the above information is complete and accurate to the best of my knowledge and belief.*

Print Name of Authorized Representative: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

*This Application must be completed, dated and signed by the CEO, CFO, Administrator, Executive Director or Risk Manager of the Applicant, who is authorized to sign on behalf of all proposed Insureds.*

*Save form first on your computer before emailing.*