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

**APPLICATION FOR PSYCHIATRISTS’ PROFESSIONAL AND BUSINESS LIABILITY
INSURANCE COVERAGE**

Offered through the Professional Counselors Purchasing Group, Inc.

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

Notice to Iowa Applicants:
License # IA000000010776 issued to Richard C. Imbert

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

THIS APPLICATION IS FOR COVERAGE TYPE: CLAIMS-MADE OCCURRENCE-BASED

NOTICE: THE COVERAGE OF A CLAIMS-MADE POLICY IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED, OR PROCEEDINGS FIRST BROUGHT, DURING THE POLICY PERIOD, AND REPORTED IN WRITING TO THE INSURER IN ACCORDANCE WITH THE TERMS OF THE POLICY. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR LEGAL OR INSURANCE ADVISOR.

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE SECTION V. (C). “MAXIMUM LIMIT OF LIABILITY - 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.

PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION

1. a. Name of Applicant _____ License No.: _____
Date of Birth: _____
E-mail address: _____

b. Coverage desired (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 copy of articles of incorporation, a letter describing all services provided, any brochures if available, and a listing of owners and/or partners, indicating the percentage owned by each.**

II. APPLICANT INFORMATION

2. a. Principal Office Address: _____

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

Entity and/or Facility Name: _____

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

b. Any Other Office Address: _____

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

Entity and/or Facility Name: _____

c. Home Address: _____

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

d. If you are practicing in multiple locations which are located in different counties and/or states, please provide a percentage of time spent in each location.

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? _____ / _____ Effective date requested: _____

b. Are you interested in obtaining limits higher than \$50,000 for defense expenses 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 expenses related to licensing board investigations and other proceedings as described in the Policy:

- \$75,000 (Additional Premium \$61)
- \$100,000 (Additional Premium \$122)
- \$125,000 (Additional Premium \$183)
- \$150,000 (Additional Premium \$244)

Please include the additional premium indicated with your premium payment

III. 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 | | Number of hours practice each week | License or Certification | | | |
|------|--------|----------------|-------------------------------------|------------------|------------------------------------|--------------------------|-------|-------|-------------------------|
| | | | Association name | Membership Level | | First Year Licensed | State | Title | Board Certified? Yes/No |
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

b. Please attach a copy of a Curriculum Vitae (C.V.) for each professional and a copy of each professional’s medical license.

7. PRACTICE PROFILE

a. Does your practice include specialties? Yes No

If yes, please specify: Pediatrics General Practice Family Practice Other _____

b. Do you seek coverage for neurology practice (additional charge will apply)? Yes No

If yes, are you seeking to include coverage for neurological procedures? Yes No

If yes, please complete the Supplemental Application for Neurology with Procedures.

c. Composition of your practice: Children/Adolescents/Related Adults _____% Prisoners _____%

Adults (not related to above) _____% Sex Offenders _____% Custody Evaluation _____%

If your practice includes prisoners, is this a correctional facility? Yes No

If yes, is insurance coverage provided for these activities by such facility? Yes No

d. Do you have admitting privileges? Yes No

If no, please describe your mechanism for handling your patients who may require immediate in-patient care:

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

If no, please explain: _____

f. When prescribing medication, do you provide your patients with the risks, benefits, alternatives and side effects of the medication and note in the chart? Yes No

g. 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

If yes, for how many patients per week? _____

Do you periodically see such patient(s) for reasons other than medication management? Yes No

If yes, please describe: _____

Do you discuss risks, benefits, alternatives, and side effects of medications and note this in the patient chart? Yes No

h. 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: _____

i. Have you ever practiced a specialty other than psychiatry or neurology? Yes No

If yes, please specify: _____

j. Do you advertise as a specialist* in the evaluation and treatment of any of the following?

Borderline Personality Disorder Chronic Pain Multiple Personality Disorder or Dissociative Disorders

Childhood Sexual Abuse Eating Disorder Sex Therapy

*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.

k. Do you supervise any other psychiatrist or other mental healthcare providers specializing in the disorders/activities listed in question "j"? Yes No

l. 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. _____

m. 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.

n. Do you communicate with your patients via e-mail? Yes No

Please explain the nature of communications in detail. _____

o. 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

Yes No

What is the total practice time devoted to this activity? _____%

On a separate sheet, please explain the exact type of telemedicine activities.

p. Do you engage in any clinical trials and/or pharmaceutical research? Yes No

If yes, does the sponsor agree in writing to indemnify you for such research activities? _____

(Please include a copy of these indemnification agreements.)

If no, please explain type and extent of such activities: _____

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

If yes, please describe: _____

- r. Do you cover any ER for crisis cover? Yes No

If yes, please indicate percentage of time devoted to this activity: _____%

Is this on call? Yes No

If yes, approximately how many hours per week? _____

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, group home or nursing home? Yes No

If yes, please list institution, nature of work and hours per week. _____

- b. Are you provided malpractice coverage by a facility or place of employment, or by any other policy that covers you? Yes No

If yes, please indicate location of the facility or place of employment 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 healthcare 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.

IV. PRIOR COVERAGE HISTORY

12. a. Name of present carrier: _____ Number of years: _____

If less than 5 years, please list previous carrier as well: _____

Number of years continuously insured through an American Psychiatric Association endorsed program: _____
(Please attach copy of most recent policy declarations page.)

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

c. Limits of present coverage: _____ / _____

d. 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.) ___ / ___ / ____

e. If you selected Claims-made in Question 12 b., please check the appropriate box below:

i. The Extended Reporting Period Endorsement has been purchased on my prior policy. Yes No
If yes, please indicate the name of prior carrier: _____

ii. Prior Acts Coverage is requested on my new Claims-made policy. Yes No
If yes, please indicate Retroactive Date desired: ___ / ___ / ____
(Please submit Declarations page for all individuals listed in Question 6.)

f. If you answered No to Questions 12 e. i. and ii., please review the statement and check the box below:

I understand that I elected not to purchase the Extended Reporting Period Endorsement on my prior 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.

V. REPRESENTATIONS

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. _____

b. Has any person named in Question 6, including yourself, ever had any licensing board or professional ethics body require the surrender of a license or found any such person or 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 provide copies of charges, correspondence and any findings in order for your Application to be considered. _____

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. _____

NOTE: MISSOURI APPLICANTS DO NOT RESPOND TO QUESTION 13d.

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. _____

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. _____

f. Are there any circumstances, including any loss of private or confidential information, 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, including yourself, 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 current 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.

- 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.

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

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

- j. Are you now being, or have you ever been, treated for a serious health problem that did or can impair your ability to treat patients? Yes No

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

VI. NOTICES TO APPLICANT & FRAUD WARNINGS

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 MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

INSURANCE POLICIES ARE SUBJECT TO A 45 DAY UNDERWRITING PERIOD BEGINNING ON THE EFFECTIVE DATE OF COVERAGE. IF THE INSURER DISCOVERS A MATERIAL RISK FACTOR DURING THIS PERIOD, THEN THE INSURER SHALL RECALCULATE THE PREMIUM PROVIDED THE RISK CONTINUES TO MEET ITS UNDERWRITING STANDARDS AND NOTICE OF THE RECALCULATED PREMIUM SHALL BE SENT TO THE INSURED. THE INSURER MAY CANCEL THE POLICY IF THE RISK DOES NOT CONTINUE TO MEET ITS UNDERWRITING STANDARDS, IN WHICH CASE NOTICE OF CANCELLATION SHALL BE SENT TO THE INSURED AT LEAST 15 DAYS PRIOR TO CANCELLATION.

VII. DECLARATION AND SIGNATURE

I understand that it is my obligation to maintain any license required in the jurisdictions in which I practice.

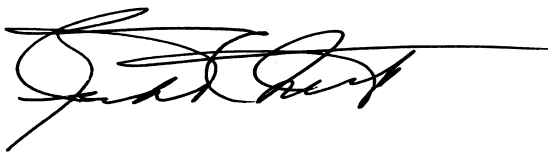
Date: _____ Signature: _____
(This application must be dated within 30 days of receipt) (APPLICANT / OWNER / PRESIDENT OF CORPORATION)
Title: _____

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.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694
www.americanprofessional.com

Producer Signature:





**IMPORTANT INFORMATION
PURCHASING GROUP FEE NOTICE**

A \$18.00 annual Purchasing Group fee needs to be added to your premium to help defer the administrative costs for maintaining the Professional Counselors Purchasing Group.

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Mail to:

American Professional Agency, Inc.

95 Broadway

Amityville, NY 11701

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