FOR OFFICE USE ONLY

PREMIUM:
RATED BY:
EFFECTIVE DATE:
RETRO DATE:
REFUND AMOUNT DUE:

Allied World Insurance Company ("Insurer")

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

RENEWAL APPLICATION FOR PSYCHIATRISTS' PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, 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: _____ Policy #: _____

Email 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. Have any of your responses to Questions 3, 4, 5 or 6 below changed since your completion of the prior application for this coverage? ☐ Yes ☐ No
   If yes, please respond to Questions 3, 4, 5 and 6 below.

   If no, please go directly to Section III. of this Application.

3. 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.

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

5. Office Telephone: ( ) _____ Fax #: ( ) _____ Home Telephone: ( ) _____

6. a. Change in Policy Limits Requested? _____ / _____

   b. Are you interested in changing your limits for defense expenses related to licensing board investigations and other proceedings as described in the Policy? ☐ Yes ☐ No

   If yes, choose desired limit of liability desired for defense expenses related to licensing board investigations and other proceedings as described in the Policy:

   ☐ $50,000 (included at no charge) ☐ $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

7. Have any of your responses to Questions 8, 9, 10, 11, 12 or 13 below changed since your completion of the prior

application for this coverage? ☐Yes ☐No

If yes, please respond to Questions 8 through 13 below.

If no, please go directly to Section IV. of this Application.

8. 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			
			Associa-tion name	Member-ship Level		First Year Licensed	State	Title	Board Certified? Yes/No

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

9. 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

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? _____

10. 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 8(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:_____

11. Do you serve on a HMO, PPO or any other type of peer review board? ☐Yes ☐No

If yes, please describe: _____

12. 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 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 health care service to which you refer your patients? ☐Yes ☐No

If yes, please specify and fully explain._____

13. 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.

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

_____

V. 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.

VIII. DECLARATION AND SIGNATURE

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

NOTICE TO NEW YORK 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, 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."

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

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

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

Producer Signature:

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

ADDENDUM TO APPLICATION

Name of Applicant: _____

If you have answered YES to Question #12a of the application, please complete the following questions:

1. Please list the institution(s) and indicate the hours you practice at each:

Institution Name	Number of Hours

2. Please describe the nature of work done at each facility:

   _____

   _____

   _____

3. Are you doing in-patient work? _____Yes _____No
   If yes, are you treating your own patients or the facility's patients?

   _____

   If they are the facility's patients and they are assigned to you, are you the only treating psychiatrist while they are at the facility? _____Yes _____No
   If no, please explain_____

   _____

Please note: If the facility covers you for your work, it will be excluded from coverage. If you are not covered by the facility, it is possible that a debit may be applied to cover you for the additional exposure you have. This would apply especially in the case where you are not the only treating psychiatrist for the patients to whom you are assigned.

ADDENDUM TO APPLICATION FOR PSYCHIATRISTS PROFESSIONAL LIABILITY COVERAGE NEW YORK

NY Medical Malpractice Excess Coverage Questionnaire

Name:_____

Address:_____

Telephone·Number:_____

Email:_____

Do you currently participate in the New York Medical Excess Liability Program? ◯yes ◯no
If Yes, please provide the information requested below:

(1) Do you currently have limits of liability of $1.3 million/$3.9 million on your primary professional liability policy? ◯yes ◯no
(2) Do you have a primary affiliation with a New York State general hospital with professional privileges? ◯yes ◯no
(3) Have you completed a qualified Risk Management course within the last two years? ◯yes ◯no
(4) Have you had an Excess policy for all or part or each of the 3 previous years? ◯yes ◯no
(5) What Risk Management courses have you completed in the last 3 years?

_____

_____

_____

_____

Note: If you have completed a Risk Management course in the last year you may be eligible for a 5% discount on your premium. However, it must be a qualified course approved by the State of New York. You must take qualified Foundation course prior to taking any Follow Up courses in order to be eligible. For more information contact us at 877-740-1777.

NOTICE TO NEW YORK APPLICANTS

Please note, the Limit of Liability for Defense Reimbursement for Licensing Board Hearings on the Psychiatrist Professional Liability Policy is $5,000. This is included at no additional charge. If you wish to have higher limits, the additional amounts and premiums are as follows:

Defense Limit: _____ $10,000 premium $75.00

_____ $25,000 premium $95.00

_____ $50,000 premium $110.00

If you elect to have higher limits for defense costs related to Licensing Board Hearings, simply check the desired limit and include the additional premium in your check. Please return this form with your application.

If you have any questions, please call 800-421-6694.

American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 – (800) 421-6694

CLAIM ACTIVITY

Be sure to answer all question fully, leave no blanks.

a) Name of claimant or plaintiff:_____
(Last) (first) (Middle)

Age:_____ Sex:_____ Marital Status:_____

b) Date of alleged incident:_____

c) Location of incident (Hospital, office, clinic, etc.) :_____

d) Issue or type of injury claimed: - What was the objective issue contested in this claim ?

Injury: ☐ Emotional Only ☐ Cosmetic ☐ Temporary Disability ☐ Permanent Disability ☐ Death

Diagnosis:_____

Prognosis:_____

Prior Treating Physicians:_____

Subsequent Treating Physicians:_____

_____

e) Were other physicians or hospitals involved as co-defendants ? ○ No ○ Yes Please list names: _____

_____

f) Name of insurance company defending you: _____

g) Was claim or suit: ☐ actually brought against you ☐ merely threatened, or ☐ limited to claimants attorney contact?

h) Disposition of claim:

☐ Abandoned (no activity over 3 years)

☐ Won by defense

☐ Judgement or verdict vs. co-defendant(s) only

☐ Settled ☐ won by claimant. If so, how much was paid on your behalf? _____

_____

☐ Open (State Current Status) _____

Narrative Description of Incident _____

_____

_____

Please photocopy this form and supply us with separate information for each claim, suit or incident.
CAP-SUP (6/00)

QUARTERLY BILLING FORM

PLEASE READ THE FOLLOWING INFORMATION CONCERNING OUR QUARTERLY BILLING PROCEDURE

The following procedures will be followed if you choose to pay your premium quarterly:

1. A bill will be issued to you 45 days prior to the due date for each quarterly payment.

2. Since we are required to give you advance notice that your coverage will lapse if payment is not received, a notice is sent on the due date stating that if payment is not received your policy will be cancelled on the date indicated on the cancellation notice. This is done for state regulations and also serves in some cases as a reminder that payment has not been received.

3. If a notice of cancellation is sent out and payment is then received prior to the cancellation date, a letter voiding out the cancellation will be provided to you.

I wish to make my payments in installments. I have remitted 35% of the annual premium. I understand that I will be billed for the remaining quarters and a $5.00 service charge will be included in each quarterly bill. A $20.00 service charge will be assessed to each quarterly payment which is returned for uncollected funds.

E-mail address: _____

Signature: _____ Date:_____

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.

Please make check payable to:

American Professional Agency, Inc.

Mail to:

American Professional Agency, Inc.
95 Broadway
Amityville, NY 11701

Click Here!

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