



Allied World Insurance Company (“Insurer”)

FOR OFFICE USE ONLY

PREMIUM:

RATED BY:

EFFECTIVE DATE:

RETRO DATE:

REFUND AMOUNT DUE:

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			
			Association name	Membership 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.

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. REPRESENTATIONS

14. After inquiry* of each individual listed in Question 8**:

* "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.

** In the event Question 8 above has not been completed, "each individual listed in Question 8" shall include those individuals listed in your prior application for this coverage.

a. Has any person named in Question 8, 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 8, 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 8, 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. _____

d. Has any person named in Question 8, 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 8, 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 8, including yourself, is aware of that may result in any professional liability claim or suit being made against any person named in Question 8, 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. _____

- g. Is any person named in Question 8, 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 8, 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 8, 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.

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 it is 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.

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:

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.

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 _____

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!

For your FREE, first-time listing in [Psychology Today's Therapy Directory](#).

Start getting clients - A \$180 value from APA, Inc.