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PROFESSIONAL & GENERAL LIABILITY APPLICATION

NEGLEY
ASSOCIATES
UNDERWRITING MANAGERS

103 Eisenhower Parkway, Suite 101, Roseland, NJ 07068
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**APPLICATION FOR
PROFESSIONAL AND GENERAL LIABILITY COVERAGE**

**For this application to be processed in a timely fashion, please answer every question completely.
If a question is not applicable, please write N/A. Do not leave any space blank.**

1. Name of Insured _____

2. Physical Address:
Street _____ City _____ State _____ Zip _____

CEO Name _____ Phone # _____ Fax # _____ Email _____

CFO Name _____ Phone # _____ Fax # _____ Email _____

Website _____

3. Type of Organization:
Individual _____ Corporation, for profit _____
Partnership _____ Corporation, nonprofit _____
Trust _____ Limited Liability Company (LLC) _____

4. Describe the purpose of the organization (attach brochures)

5. If more than one Named Insured is listed above, please explain the ownership and operational relationships.

6. Number of years in operation _____

7. Has any license or accreditation ever been suspended, denied or revoked? _____

8. Of what professional association(s) is the Insured a member in good standing? _____

9. Projected annual operating budget \$ _____ **Include current Audited Financial Statement.**

10. Current Insurance:

| Professional Liability | General Liability |
|--|--|
| Company _____ | Company _____ |
| Inception Date: _____ Expiration Date: _____ | Inception Date: _____ Expiration Date: _____ |
| Premium \$ _____ | Premium \$ _____ |
| Deductible \$ _____ | Deductible \$ _____ |
| Limit of Liability \$ _____ | Limit of Liability \$ _____ |
| Occurrence Form? _____ or Claims Made? _____ | Occurrence Form? _____ or Claims Made? _____ |
| If Claims Made form, Retroactive Date _____ | If Claims Made form, Retroactive Date _____ |

11. Limits Requested: Professional Liability \$ _____ General Liability \$ _____

12. Has any company cancelled or declined to renew insurance? If yes, please explain. **(Not applicable to Missouri applicants)**

13. Have there been any claims or lawsuits in the last five years? Yes No

Date of Loss Amount Paid or Reserved Claimant's Name/Description of Claim (Attach separate sheet if necessary)

14. Are there any circumstances known which may give rise to a claim or lawsuit? Yes No If yes, please explain. (Attach separate sheet if necessary)

It is understood that with respect to Questions 13 & 14 above, any claim or action arising out of such facts, circumstances or situations is excluded from the proposed coverage.

15. Schedule of Employees:

| | Number of | | |
|------------------------------|-----------|-----------|-----------|
| | Full Time | Part Time | Volunteer |
| Administrators | _____ | _____ | _____ |
| Case Managers | _____ | _____ | _____ |
| Clerical | _____ | _____ | _____ |
| Counselors | _____ | _____ | _____ |
| Homemakers/Aides | _____ | _____ | _____ |
| Nurses (LPN) | _____ | _____ | _____ |
| Nurses (RN) | _____ | _____ | _____ |
| Nurse Practitioners | _____ | _____ | _____ |
| Psychologists | _____ | _____ | _____ |
| Physician Assistants | _____ | _____ | _____ |
| Social Workers | _____ | _____ | _____ |
| Students | _____ | _____ | _____ |
| Others, please specify _____ | _____ | _____ | _____ |

16. Schedule of Physician Staff (Employed, Contracted or Volunteer) if none, write "none" _____

| Name | Specialty | Board Certified | Board Eligible | Hours/Week Worked | Employed, Contracted or Volunteer (E, C or V) | Carries own Malpractice Insurance | |
|-------|-----------|-----------------|----------------|-------------------|---|-----------------------------------|--------------------------|
| | | | | | | Yes | No |
| _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

17. Do you wish physicians to be covered under the Center's policy? Yes No **(Not applicable to Pennsylvania applicants)**

18. Are drugs or medication administered or prescribed? Yes No If yes, please explain.

19. Is electroshock therapy utilized? Yes No If yes, how many times per year? _____

20. Do you provide, or anticipate providing in the next year, primary medical care? (Primary medical care means the evaluation, diagnosis, and non-surgical treatment of common illnesses and medical conditions.) Yes No

21. Do you contract, or plan to contract in the next year, with another agency for primary medical care? Yes No

If you answered yes to either of the above two questions, give details below:

A. Do you currently provide primary medical care? Yes No

B. Do you anticipate providing primary medical care in the next year? Yes No

C. Do you currently have any volunteer, contracted, or employed physicians providing primary medical care?
Yes No If yes, give details below:

1. Do primary medical care physicians carry their own insurance? Always Sometimes Never
2. If a physician carries his/ her own insurance, does this individual coverage specify that coverage extends to services provided to your center's patients? Always Sometimes Never
3. Is your center an additional insured on the physician's policy? Always Sometimes Never
4. Do you obtain a certificate of insurance evidencing the physician's coverage and your Additional Insured status?
Always Sometimes Never

D. Do you anticipate having any volunteer, contracted, or employed physicians providing primary medical care in the next year?
Yes No If yes, answer questions below:

1. Will primary medical care physicians carry their own insurance? Always Sometimes Never
2. If a physician carries his/ her own insurance, will you require that this individual coverage specify that coverage extends to services provided to your center's patients? Yes No
3. Will you require that your center be added as an additional insured on the physician's policy? Yes No
4. Will you obtain a certificate of insurance evidencing the physician's coverage and your Additional Insured status?
Yes No

E. Do you contract with a Federally Qualified Health Center? Yes No
 If yes, are your physicians covered under the Federal Tort Claims Act? Yes No
 Are your non-physician primary care providers covered under the FTCA? Yes No

F. Do you plan to contract with an FQHC in the next year? Yes No

G. Are you an FQHC? Yes No (If yes, please provide a copy of your federally approved project scope.)

H. Do you plan to become or merge with an FQHC in the next year? Yes No

22. Schedule of Locations: (Attach separate sheet if necessary.)

| Loc. # | Complete Address (including zip code) | Sq. Feet | Type of Services Provided |
|--------|---------------------------------------|----------|---------------------------|
| | | | |
| | | | |
| | | | |

23. List of Additional Insureds: (If none, write "none"_____)

| Name and Address (including zip code) | Interest |
|---------------------------------------|----------|
| | |
| | |
| | |

24. Units of Service – Please indicate the number of units of each service rendered by the facility, where appropriate:

Licensed Bed Capacity:

| | | | |
|-------------------------|-------|-----------------------|-------|
| Mental Health Inpatient | _____ | Group Home | _____ |
| Alcohol/Drug Inpatient | _____ | Shelters | _____ |
| Alcohol/Drug Detox | _____ | Independent Living | _____ |
| Halfway House | _____ | Foster Care | _____ |
| | | Other, please specify | _____ |

Annual Outpatient or Client Visits:

| | | | |
|--------------------|-------|-----------------------|-------|
| Alcohol/Drug Rehab | _____ | Counseling | _____ |
| Mental Health | _____ | Other, please specify | _____ |

Clients per Day:

| | | | |
|-----------------|-------|-----------------------|-------|
| Adult Day Care | _____ | Day Treatment | _____ |
| Child Day Care | _____ | Sheltered Workshops | _____ |
| Case Management | _____ | Other, please specify | _____ |

Annual Calls:

| | | | |
|----------|-------|-----------------------|-------|
| Hotline | _____ | Information | _____ |
| Referral | _____ | Other, please specify | _____ |

Annual Employee Assistance Programs (EAP) Contacts or Visits:

| | | | |
|-------------|-------|---------------------------------|-------|
| Assessments | _____ | Counseling Visits | _____ |
| Referrals | _____ | No. of Companies under Contract | _____ |

Home Health Care Visits:

| | | | |
|-----------------------|-------|-----------------------|-------|
| Nonprofessional Hours | _____ | IV Therapy | _____ |
| Professional Hours | _____ | Other, please specify | _____ |

Miscellaneous:

| | | | |
|----------------|-------|------------------------|-------|
| Mentor Matches | _____ | Annual Methadone doses | _____ |
|----------------|-------|------------------------|-------|

Attach an application supplement for Residential or Inpatient, Day Care, Pre-School, Headstart, Methadone/Buprenorphine, Foster Care/Adoption, Sheltered Workshops/Products, if applicable.

25. Are there any camps, adventure/wilderness, ropes courses, or any type of recreational programs? If yes, please provide descriptive material.

26. Are there any swimming or boating activities? If yes, please provide details.

Very Important — Please attach copies of all available descriptive materials and/or brochures on your operations.

This application does not bind you nor us to complete the insurance, but it is agreed this form will be the basis of the contract should a policy be issued. This form will be attached to and become a part of this policy.

FRAUD WARNING: 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 or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Not applicable to Nebraska, Oregon or Vermont applicants)

FRAUD WARNING (Applicable in Tennessee, Virginia and Washington): It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

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.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO RHODE ISLAND 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.

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, 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.

Signature: _____ Title: _____
(Must be signed by the Executive Director)

Please print or type name Date

Producer's Name Area Code Phone Number

Agent Name: _____ Agent License Number: _____
(Applicable to Florida Agents Only)

Iowa Licensed Agent: _____
(Applicable to Iowa Agents Only)

Producer's Signature: _____ Date: _____
(Applicable to New Hampshire Producers Only)