APPLICATION FOR MENTAL HEALTH/MENTAL RETARDATION FACILITIES PROFESSIONAL LIABILITY
(Claims Made Coverage)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. If the answer to any question is none, state NONE.
4. Please do not complete application earlier than 45 days before proposed effective date of coverage.
5. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full Name of Applicant: _____

b. Principal Business Address: _____
Street City State Zip Code

c. List locations of all facilities:

Location No.	Name and Location of Facility	Type of facility: Halfway House; Group Home; Inpatient; Contract Beds; Outpatient - Describe below in detail	Type of Patient: Child/ Adult/Aged; Mentally Retarded; Ex-offender; Emotionally Disturbed; Physically Handicapped; Other - Please be specific	No. Of Beds and Average Percentage Occupancy (%)	No. Of Outpatient Visits* Last 12 Months; Next 12 Months	List all Services rendered (e.g., alcohol or drug detoxification; confrontation, shock, rage, sex or gas therapy; vocational rehab; hypnosis; surgery, types of counseling, etc.)
1	____sq. ft.			No. %	Last: Next:	
2	____sq.ft.			No. %	Last: Next:	
3	____sq.ft.			No. %	Last: Next:	
4	____sq.ft.			No. %	Last: Next:	
5	____sq.ft.			No. %	Last: Next:	
6	____sq.ft.			No. %	Last: Next:	
7	____sq.ft.			No. %	Last: Next:	
8	____sq.ft.			No. %	Last:	

* "Outpatient Visits" refers to number of visits or patient encounters--not number of patients. If annual figures are not available, please attach an explanation and estimate number of patients/clients served on an average day.

d. Professional societies or associations in which applicant is a member: _____

e. Applicant is: ◯ Professional Corporation (for profit) ◯ Partnership ◯ Professional Corporation (non-profit) ◯ Professional Association ◯ Other _____

f. The business, corporate or partnership name is: _____

g. Give names of all partners or members of the firm who provide professional services: _____

_____

_____

h. Year established:_____ Applicant's professional specialty: _____

i. Are the facilities listed in Question 1(c) licensed in accordance with all applicable local, state and federal laws and regulations? ◯ Yes ◯ No. If no, attach separate explanation for each facility which is NOT licensed accordingly.

j. Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism?..... ◯ Yes ◯ No

2. STAFF

a. Number of professional employees, volunteers, and independent contractors

	LOCATION NO.							
EMPLOYEES	1.	2.	3.	4.	5.	6.	7.	8.
MDs								
Psychologists								
Social Workers								
RNs								
LPNs/Nurse's Aides								
Pharmacists								
Nurse Practitioners								
Other (Describe qualifications & duties separately)								
Volunteers								
INDEPENDENT CONTRACTORS								
MDs								
Psychologists								
Social Workers								
RNs								
LPNs/Nurse's Aides								
Pharmacists								
Nurse Practitioners								
Other (Describe qualifications & duties separately)								

b. Are all of the above **employees** licensed in accordance with applicable and federal regulations?..... ◯ Yes ◯ No
If no, attach explanation.

c. Do any of the above **employees** and **volunteers** carry their own professional liability insurance?..... ◯ Yes ◯ No
If yes, provide details. _____

_____

3. APPLICANT OPERATIONS

a. Sources and amounts of total revenues:

Source	**Amount This Fiscal Year**	**Amount Next Fiscal Year**
Charitable Contributions	$_____	$_____
Government Funding	$_____	$_____
Fee for Service	$_____	$_____
TOTAL GROSS REVENUE	$_____	$_____

b. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory? ..... ◯ Yes ◯ No
If yes, please attach a copy of ALL of the advertisements.

c. Is the applicant associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? ..... ◯ Yes ◯ No

If yes, please attach detailed explanation and a copy of ALL of the advertisements.

d. Does the applicant participate in any activity, e.g., newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? ..... ◯ Yes ◯ No
If yes, please attach detailed explanation of this activity.

e. Does the applicant administer any methadone treatment? ..... ◯ Yes ◯ No
If yes, please describe treatment and controls used and indicate number of treatments during the last 12 months _____ Next 12 months _____

f. Hold Harmless (Indemnification) Agreements:

(i) In favor of the applicant--if the applicant has obtained any written indemnification agreements holding the applicant harmless, describe and indicate if certificates of insurance are obtained. _____

(ii) In favor of others--has the applicant agreed to indemnify (hold harmless) others under written contract? ..... ◯ Yes ◯ No
If yes, please submit copy of agreement.

g. Is the applicant in the employ of any governmental entity? ..... ◯ Yes ◯ No
If yes, please attach explanation. Include details of your responsibilities.

h. Is the applicant under contract to any governmental entity? ..... ◯ Yes ◯ No
If yes, please attach explanation. Include details of your responsibilities.

i. Does the applicant perform or permit any corporal punishment? ..... ◯ Yes ◯ No
If yes, please provide separate explanation.

j. Does applicant own or operate any business other than that shown in Question 1(a) above? ..... ◯ Yes ◯ No
If yes, please give details on separate sheet.

k. Please describe in detail any additional activities and/or procedures performed by the applicant, including any off-premises exposures: _____

_____

l. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... ◯ Yes ◯ No
If yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... ◯ Yes ◯ No

(ii) Provide the name and title of the Applicant's Privacy Officer. _____

Our Business Associate Agreement is available at https://www.markelcorp.com/US-Insurance/HIPAA. This is the only Business Associate Agreement we will recognize.

4. GENERAL LIABILITY

a. Answer questions below only if General Liability coverage for Locations in 1(c) is requested.

	LOCATION NO.							
QUESTIONS	1.	2.	3.	4.	5.	6.	7.	8.
Year Built								
Year Remodeled								
No. of Stories								
Construction:								
Exterior Walls								
Roof								
Floors								

Is the building equipped with:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
At least 2 clearly-marked exits on each floor?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Self-closing fire doors on each floor?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Exit doors of at least 42" width from all sleeping, diagnostic & treatment rooms?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Automatic fire alarm system connected to local fire department?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Smoke detectors?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Emergency electrical system?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Heat sensors?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Fire escape(s)	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Is any new construction contemplated for the next 12 months? If yes, attach details including estimated contract costs, number of beds, sq. ft., planned use, date of completion, etc.	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯

5. CLAIMS

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or any employees:

a. Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? ..... ◯ Yes ◯ No

b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... ◯ Yes ◯ No

c. Ever been treated for alcoholism or drug addiction? ..... ◯ Yes ◯ No

d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrender same? ..... ◯ Yes ◯ No

e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ..... ◯ Yes ◯ No

f. Has any claim or suit been brought against the applicant and/or any of its employees? ..... ◯ Yes ◯ No
If yes, a supplemental claims information form must be completed for each claim or suit.

g. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice or general liability claim or suit being made or brought against the applicant or any of its employees? ..... ◯ Yes ◯ No
If yes, please give details: _____

_____

h. List professional liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Co.	Policy No.	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retroactive Date
							[◯]	[◯]	
							[◯]	[◯]	
							[◯]	[◯]	
							[◯]	[◯]	
							[◯]	[◯]	

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof**.

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.