Application

SOCIAL WORKER PROFESSIONAL LIABILITY POLICY

FL- 138 SOCIAL WK PI

NOTE: PLEASE TYPE OR PRINT LEGIBLY, ALL QUESTIONS MUST BE ANSWERED

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGEMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE THE SPECIAL PROVISION "SEXUAL MISCONDUCT" IN THE POLICY).

1. (A) NAME OF APPLICANT ______________________________

(B) COVERAGE DESIRED (CHECK ONE):

[ ] INDIVIDUAL [ ] PARTNERSHIP [ ] PROFESSIONAL CORPORATION (INCORPORATED AS A P.C. OR P.A.)

[ ] GENERAL BUSINES CORPORATION ____________ PROFIT ______________ NON PROFIT 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, A DESCRIPTION OF SERVICES OFFERED MUST BE INCLUDED. PLEASE INCLUDE ANY BROCHURES, IF AVAILABLE, AND A LETTER OUTLINING ALL DETAILS REGARDING SERVICES OFFERED BY YOUR ORGANIZATION.

2. MAILING ADRESS: ______________________________

BUS. PHONE # ______________________________

3. LIMIT OF LIABILITY DESIRED (CHECK ONE)

(LIMITS OF LIABILITY APPLY TO: EACH WRONGFUL ACT OR SERIES OF CONTINUOUS, REPEATED OR INTERRELATED WRONGFUL ACTS OR OCCURRENCE/AGGREGATE.)

[ ] $100,000/300,000 [ ] $200,000/600,000 [ ] $1,000,000/1,000,000

4. LIST YOUR NAME AND QUALIFICATIONS. IN ADDITION, LIST THE NAMES AND QUALIFICATIONS OF ALL YOUR SALARIED (W2) EMPLOYEES, EXCEP CLERICAL. IF YOU ARE APPLYING FOR A PARTNERSHIP POLICY, PLEASE LIST ALL PARTNERS AS WELL. PLEASE INCLUDE THE PREMIUM CHARGE INDICATED ON THE RATE SCHEDULE FOR YOURSELF AND ECH EMPLOYEE AND/OR PARTNER.

			PLEASE CHECK THE APPROPIATE BOX (ES)			
NAME	ACADEMIC DEGREE	FIELD OF STUDY	ACADEMY OF CERTIFIED SOCIAL WORKERS	MASTERS DEGREE IN SOCIAL WORK	FULL REGULAR MEMBER OF NASW	FULL TITLE OF YOUR LICENSE OR CERTIFICATION AND THE FIELD OF PRACTICE AND STATE IN WHICH YOU HOLD IT.
			[ ]	[ ]	[ ]	
			[ ]	[ ]	[ ]	
			[ ]	[ ]	[ ]	
			[ ]	[ ]	[ ]	
			[ ]	[ ]	[ ]	
			[ ]	[ ]	[ ]	
			[ ]	[ ]	[ ]	
			[ ]	[ ]	[ ]	

5. PLEASE LIST THE NUMBER OF YOUR ENTIRE EMPLOYED STAFF (EXCEPT CLERICAL) INCLUDING YOURSELF. ____________

____

NOTE: STAFF IS DEFINED AS YOUR DIRECT EMPLOYEES (FOR WHOM YOU FILE A W2 FORM) AND THEIR NAMES AND CREDENTIALS MUST BE INCLUDED WITH YOURS UNDER QUESTION 4 TO CORRESPOND WITH THE NUMBER LISTED HERE.

6. AFTER INQUIRY OF EACH PERSON NAMED IN QUESTION 4:

"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 4, INCLUDING YOURSELF, EVER BEEN CONVICTED OF OR CHARGED WITH A CRIME IN ANY STATE OR COUNTRY, THE DISPOSITION OF WHICH WAS OTHER THAN ACQUITTAL OR DISMISSAL? YES [ ] NO [ ]

If yes, please the full particulars in order for your application to be considered. ______

(B) HAS ANY PERSON NAMED IN QUESTION 4, INCLUDING YOURSELF, EVER HAD ANY LICENSING BOARD OR PROFESSIONAL ETHICS BODY EVER REQUIRE YOU TO SURRENDER YOUR LICENSE YES [ ] NO [ ]

If yes, please the full particulars in order for your application to be considered. ______

(C) ARE THERE ANY COMPLAINTS OR CHARGES PENDING AGAINST ANY PERSON NAMED IN QUESTION 4, INCLUDING YOURSELF, BY ANY 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 the full particulars in order for your application to be considered. ______

7. (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: ______

8. ARE YOU OR ANY PERSON NAMED IN QUESTION 4 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. HAS ANY PERSON NAMED IN QUESTION 4 EVER HAD PROFESSIONAL LIABILITY COVERAGE? YES [ ] NO [ ]
   If yes, please list:

   NAME OF CARRIER: ______

   LIMITS OF LIABILITY: ______

   PREMIUM: ______

   EXPIRATION DATE: ______

10. *AFTER INQUIRY OF EACH PERSON NAMED IN QUESTION 4:

*"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 PROFESSIONAL LIABILITY CLAIM OR SUIT EVER BEEN MADE AGAINST ANY PERSON NAMED IN QUESTION 4, INCLUDING YOURSELF, THEIR PREDECESSORS IN BUSINESS OR AGAINST ANY PAST OR PRESENT PARTNERS? YES [ ] NO [ ]

If yes, please give full particulars for each claim in order for your application to be considered. ______

(B) ARE THERE ANY CIRCUMSTANCES OF WHICH ANY PERSON NAMED IN QUESTION 4, INCLUDING YOURSELF, IS AWARE OF THAT MAY RESULT IN ANY PROFESSIONAL LIABILITY CLAIM OR SUIT BEING MADE AGAINST ANY PERSON NAMED IN QUESTION 4, THEIR PREDECESSORS IN BUSINESS OR AGAINST ANY PAST OR PRESENT PARTNER? YES [ ] NO [ ]

If yes, please give full particulars for each claim in order for your application to be considered. ______

(C) HAS ANY PERSON NAMED IN QUESTION 4, 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 for each claim in order for your application to be considered. ______

11. (A) DOES THE APPLICANT USE ANY INDEPENDENT CONTRACTORS OR CONSULTANTS (1099 FORM) WHOSE SERVICES ARE IN A MENTAL HEALTH FIELD AND FOR WHOM YOU DO BILLING, SHARE FEES WITH OR IN ANY WAY DERIVE INCOME FROM THE RELATIONSHIP? YES [ ] NO [ ]

    (B) IF YES, PLESE LIST THE NAME AND PROFESSIONAL CREDENTIALS OF EACH ONE.

THE INDEPENDENT CONTRACTOR (1099 FORM) CHARGE SHOWN ON THE RATE SCHEDULE MUST BE INCLUDED FOR EACH CONTRACTOR OR CONSULTANT LISTED AND ADDED TO YOUR PREMIUM. YOU WILL BE COVERED FOR THEIR ACTS 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.

FOR OFFICE USE ONLY

INDEPENDENT CONTRACTORS: ______________________ MARRIAGE & FAMILY COUNSELORS ______________________

PASTORAL COUNSELORS ______________________ PSYCHIATRISTS ______________________

PSYCOLOGISTS ______________________ SOCIAL WORKERS ______________________

OTHERS ______________________

I HEREBY ATTEST THAT THE FOREGOING STATEMENTS ARE TRUE AND ACCURATE AND MAY BE RELIED UPON BY THE COMPANY/UNDERWRITER FOR THE PURPOSES OF ISSUING THIS COVERAGE.

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD PROVIDES FALSE INFORMATION IN AN INSURANCE APPLICATION, OR PRESENTS, ASSISTS, OR MAKES A FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS OR OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR THE SAME INCIDENT OF DAMAGE OR LOSS, WILL COMMIT A FELONY AND IF CONVICTED WILL BE SENTENCED FOR EACH VIOLATION WITH A FINE OF NO LESS THAN FIVE THOUSAND ($5,000) DOLLARS AND NOT EXCEEDING TEN THOUSAND ($10,000) DOLLARS, OR BE SENTENCED TO IMPRISONMENT FOR A THREE (3) YEAR TERM, OR BOTH PENALTIES. IN THE EVENT OF AGGRAVATING CIRCUMSTANCES, THE TERM COULD BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS; IN THE EVENT OF INTERVENING EXTENUATING CIRCUMSTANCES IT COULD BE REDUCED UP TO A MINIMUM OF TWO (2) YEARS.

DATE: ______________________ SIGNATURE: ______________________

TITLE: ______________________

SIGNING THIS FORM AND TENDERING PREMIUM DOES NOT BIND THE APPLICANT OR THE COMPANY/UNDERWRITER TO COMPLETE THE INSURANCE. APPLICATION MUST BE SIGNED, DATED, FULLY COMPLETED AND ACCOMPANIED BY THE PREMIUM TO BE CONSIDERED.