

**APPLICATION FOR PROFESSIONAL &  
GENERAL LIABILITY COVERAGE**

Effective Date Requested: \_\_\_\_\_ Date Quotation Desired: \_\_\_\_\_

Limits:  \$100,000/200,000  \$1,000,000/\$1,000,000  \$1,000,000/3,000,000  \$2,000,000/6,000,000

**GENERAL INFORMATION**

1. Applicant: \_\_\_\_\_
2. Mailing Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Person to Contact: Name \_\_\_\_\_ Title \_\_\_\_\_  
Telephone Number: \_\_\_\_\_
4. Applicant is:  Individual  Partnership  Corporation  Other Describe: \_\_\_\_\_
5. Type of Business:  General  Non-Profit Organization  For Profit Organization  
Year business started or date of incorporation \_\_\_\_\_
6. Annual Revenue/Budget: \$ \_\_\_\_\_ Gross sales, if any: \$ \_\_\_\_\_
7. Major funding source: \_\_\_\_\_
8. States in which Applicant is licensed to do business: \_\_\_\_\_
9. Is Applicant a member of any association?  Yes  No If yes, please state: \_\_\_\_\_
10. Is Applicant accredited by an association?  Yes  No If yes, please state: \_\_\_\_\_
11. Briefly describe the services offered by the Applicant and attach any of the Applicant's brochures.  
 Outpatient (If so, complete supp.)  Residential (If so, complete supp.)  Daycare (If so, complete supp.)  
 Sheltered Workshop (If so, complete supp.)
12. Do you provide any of the following services?  
 Foster Care  Child Placement  Adoptions  Treatment of violent or sex offenders  Alternative Incarceration

**PRIOR INSURANCE**

Does the Applicant carry Professional Liability Insurance now?  Yes  No General Liability Insurance?  Yes  No  
If yes, describe below for both lines of coverage:

Insurer: GL \_\_\_\_\_  
PL \_\_\_\_\_

Occurrence Form:  Yes  No  
Claims Made:  Yes  No

Limit of Liability: GL \$ \_\_\_\_\_ PL \$ \_\_\_\_\_  
Annual Premium GL \$ \_\_\_\_\_ PL \$ \_\_\_\_\_  
Inception Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

If Yes advise retroactive date: \_\_\_\_\_

Has the prior carrier indicated an intent not to renew?  Yes  No

If yes, please explain: \_\_\_\_\_

Is Agent the current broker of record?  Yes  No

**PAST CLAIM ACTIVITIES**

Describe all previous lawsuits, claims or incidents resulting in complaints made against the Applicant involving any allegation of a professional nature during the past five years including date of loss and amount paid or reserved.

Are you aware of any facts or circumstances or any actual or alleged act, error or omission which may result in claims being made against the Applicant or its employees or its volunteers?  Yes  No

If yes, please explain: \_\_\_\_\_

**PROFESSIONAL STAFF**

Please provide a breakdown on the following:

Schedule of Non-physician Staff	Number		Schedule of Non-physician Staff	Number	
	Full Time	Part Time		Full Time	Part Time
Executive Director			Social Workers		
Administration			Students		
Counselors			Volunteers		
Psychologists			Clerical		
Nurses, R.N.			Physical Therapists		
Nurses, L.P.N.			Others - Identify		

Full Time = More than 20 hours per week

Part Time = Less than 20 hours per week

**REFERRALS TO OTHER INSTITUTIONS**

Number of Annual Referrals     0 to 100     101 to 500     501 to 1,000     Over 1,000

**PHYSICIANS**

Schedule of Medical or Osteopathic Doctors, Psychiatrists, Dentists, Podiatrists or Chiropractors:

Name	Specialty	Board Certified	Board Eligible	Hours worked/ Week	Employed or Contracted	A) Does Physician carry own Malpractice? B) Is Physician covered for his/her acts while working for applicant?	Carrier, Limits & Effective Dates
						A) <input type="checkbox"/> Yes <input type="checkbox"/> No B) <input type="checkbox"/> Yes <input type="checkbox"/> No	
						A) <input type="checkbox"/> Yes <input type="checkbox"/> No B) <input type="checkbox"/> Yes <input type="checkbox"/> No	
						A) <input type="checkbox"/> Yes <input type="checkbox"/> No B) <input type="checkbox"/> Yes <input type="checkbox"/> No	
						A) <input type="checkbox"/> Yes <input type="checkbox"/> No B) <input type="checkbox"/> Yes <input type="checkbox"/> No	
						A) <input type="checkbox"/> Yes <input type="checkbox"/> No B) <input type="checkbox"/> Yes <input type="checkbox"/> No	
						A) <input type="checkbox"/> Yes <input type="checkbox"/> No B) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Note: If more than 6 Physicians, schedule separately.

**CREDENTIALS AND EMPLOYMENT PRACTICES**

- Has the organization been inspected by any state or professional agency?  
Please attach a copy of the latest inspection or survey.     Yes  No
- Is a copy of each Professional's license held on file by the Agency?  
Are procedures in place to verify that a current license is maintained?  
Do you obtain certificates of insurance from all professionals?     Yes  No
- Is there a written service or referral agreement between the organization and medical Professionals?  
If Yes, is there a hold harmless or indemnification agreement in favor of the Organization?     Yes  No
- Describe the records maintained by the organization on providers of the Health Care Services.

5. What is the caseload of an individual Social Worker? \_\_\_\_\_ / \_\_\_\_\_  
Average Minimum  
How often does a supervisor review Social Workers' cases? \_\_\_\_\_

6. Has the Agency or any of its employees been reprimanded by, refused admission or suspended/license revoked by any court, association or administrative agency?  Yes  No

If Yes, explain \_\_\_\_\_

Are employment history/references checked?  Yes  No

Are criminal records checked?  Yes  No

7. Does the organization provide any of the following Health Care Services?

- |                          |  |                           |  |
|--------------------------|--|---------------------------|--|
| Acupuncture              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Catheterization           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Feeding Tube Maintenance | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Shock Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| X-Rays                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Maintenance   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Experimental Procedures  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                           |  |

If Yes, please explain procedure \_\_\_\_\_

8. Is continuing education required by the state for licensing?  Yes  No

If No, does the organization require continuing education?  Yes  No

**SEXUAL ABUSE**

1. Does your staff's (paid and volunteer) employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses?  Yes  No

2. a. Does your state permit you to do criminal background investigations on prospective employees?

Yes  No

b. If Yes, do you routinely request and receive such background investigations?  Yes  No

3. Do you verify employment-related references?  Yes  No If Yes,  In person  By telephone

4. Do you conduct a personal interview?  Yes  No

5. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a Client/child reports someone molested him/her?  Yes  No

6. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children?  Yes  No

7. Do you have a written crisis management plan for dealing with staff personnel, victim, parents, authorities, and media if you have an incident of abuse?  Yes  No If Yes, attach copy.

8. a. Have you ever had an incident that resulted in an allegation of sexual abuse?  Yes  No

b. Was a claim made against you?  Yes  No

c. Was case settled?  Yes  No

d. Taken to trial?  Yes  No

e. How much money was paid as damages to the victim? \_\_\_\_\_

f. Was a formal investigation conducted by your licensing agency?  Yes  No

If Yes, provide a copy of the details.

**DECLARATION AND SIGNATURE**

The Applicant represents to the best of his/her knowledge and belief that the statements set forth herein are true and include all material information.

The Applicant further represents that if the information supplied on this application changes between the date of its application and the inception date of the policy period, he/she will immediately notify GBT Insurance Agency Solutions LLC of such change. Signing of this application does not bind GBT Insurance Agency Solutions LLC to offer nor the Applicant to accept insurance, but it is agreed that this application and any attachments thereto shall be the basis of the insurance and the policy will be issued in reliance on those representations.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Principal, Partner or Officer

*The following statements are required by the regulations of the following state Insurance Departments. It is a requirement of certain states that this signed statement is attached to the policy. Please read the statement applicable to your state and sign where indicated.*

**CALIFORNIA APPLICANTS:** ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**FLORIDA APPLICANTS:** 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 OF THE THIRD DEGREE.

\_\_\_\_\_  
Applicant Signature Date \_\_\_\_\_

**KENTUCY 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 CONCERNING FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

\_\_\_\_\_  
Applicant Signature Date \_\_\_\_\_

**MINNESOTA APPLICANTS:** A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NEW JERSEY APPLICANTS:** ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

\_\_\_\_\_  
Applicant Signature Date \_\_\_\_\_

**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, COMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIM, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

\_\_\_\_\_  
Applicant Signature Date \_\_\_\_\_

**OHIO APPLICANTS:** ANY PERSON WHO WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

\_\_\_\_\_  
Applicant Signature Date \_\_\_\_\_

**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.

\_\_\_\_\_  
Applicant Signature Date \_\_\_\_\_

**UTAH APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT UNDERWRITING INFORMATION, FILES OR CAUSES TO BE FILED A FALSE OR FRAUDULENT CLAIM FOR DISABILITY COMPENSATION OR MEDICAL BENEFITS, OR SUBMITS A FALSE OR FRAUDULENT REPORT OR BILLING FOR HEALTH CARE FEES OR OTHER PROFESSIONAL SERVICES IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

\_\_\_\_\_  
Applicant Signature Date \_\_\_\_\_