**NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA**

Psychiatrists Professional Liability Insurance

**Group Application**

**INSTRUCTIONS:**

Y Carefully review and **answer each of the following questions.**

Y Continue with completion of the application and **return it along with a copy of your most recent certificate of insurance or declarations page and a claims history report from the carrier.**

Y If the application is complete, **the average underwriting review and processing time is 10-15 business days** from the date the application is received in the Underwriting Department. The underwriter will contact you if additional information is required.

Y Complete the application in its entirety. Do not leave any question unanswered. Please use a separate sheet of paper for any additional information, explanation or clarification.

**ALL APPLICATIONS ARE SUBJECT TO UNDERWRITING APPROVAL.**

## *If you answer “YES” to any question,*

***please provide a detailed written explanation and attach copies of all pertinent official documentation.***

|  |  |  |
| --- | --- | --- |
| Yes | No | Has any member of your group had their license to practice medicine denied, revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms? |
| Yes | No | Has any member of your group had their license to prescribe controlled substances denied, revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms? |
| Yes | No | Has any member of your group had an application for a license to practice medicine or prescribe controlled substances result in a denial? |
| Yes | No | Has any member of your group been previously or currently diagnosed with any physical or mental condition that impairs or could impair their ability to practice medicine? |
| Yes | No | Has any member of your group ever been denied a specialty board certification or re-certification? |
| Yes | No | Has any member of your group ever experienced any dependency upon or been treated for alcohol, narcotics, or other drugs? |
| Yes | No | Has any member of your group had an application (new or renewal) for hospital privileges denied, suspended, or accepted subject to conditions and restrictions? |
| Yes | No | Has any member of your group been the subject of an investigation or disciplinary proceedings by any governmental agency (e.g., State Medical Board, DEA, HHS), professional society (e.g., APA or its District Branches) or a professional review board of a hospital, HMO, PPO, or IPA? Or, are you aware of any incident that could lead to such action? (Please provide updated information for any previously reported incidences.) |
| Yes | No | Has any member of your group been charged with, convicted of, or pleaded guilty or no contest to a felony? |
| Yes | No | Has any member of your group ever been, or currently, either sexually, romantically, or socially involved with any current, or former, patient or with a key third party of a patient? (Key third parties include, but are not limited to, spouses or partners, parents, guardians, surrogates, and the like.) |
| Yes | No | Has any member of your group ever been, or currently involved in a business venture with any current or former patient or with a key third party of a patient? |
| Yes | No | Has the group or any member of your group ever had a settlement or judgment alleging undue familiarity, professional misconduct, or assault in connection with undue familiarity? **If yes**, please complete the Claims History Supplemental Application. |
| Yes | No | Has the group or any member of the group reported any malpractice claims or incidents to any carrier **other than**  the APA-endorsed Psychiatrists Professional Liability Insurance Program in the past ten years?  **If yes**, please complete the Claims History Supplemental Application. |
| Yes | No | Is the group or any member of the group aware of any incidents, occurrences, accidents, conduct, circumstances, complications, or unexpected outcomes resulting in injury or death that might reasonably be expected to result in a claim or suit known to you or which should have been known to you or any member of the group on the date of this application? **If yes**, please complete the Claims History Supplemental Application. |

**IMPORTANT INSTRUCTIONS:**

* All questions must be answered fully and completely. If any question does not apply to you, state N/A. Please use additional sheets to give complete answers where necessary.
* This is only an application. No coverage exists until a policy is issued in the group’s name.

1. **GENERAL INFORMATION: *(Please type or print)***
   1. Full Name of Applicant Group:
   2. Contact Person:
   3. Mailing Address:

First Middle Last

Street City/State/Zip

* 1. Phone: Fax: E-Mail:
  2. If we need to contact you for additional information, please indicate your preferred method of contact: Email Phone Fax
  3. Administration:

Medical Director: Quality Assurance/Improvement Dir:

Chief Financial Officer:

# OWNERSHIP STRUCTURE:

Risk Management:

 Corporation: Date and State of Incorporation Name of Majority Shareholder

 Partnership: Date and State of Incorporation Name of Majority Shareholder

 Other:

# INSURANCE AND PROFESSIONAL HISTORY:

|  |  |  |
| --- | --- | --- |
| D Yes | D No | 1. Has the applicant ever been denied professional liability insurance coverage? |
|  |  | **NOTE: MISSOURI APPLICANTS DO NOT RESPOND**  **If Yes**, please attach a separate sheet containing a complete explanation. |
| D Yes | D No | 2. Has professional liability insurance coverage ever been cancelled or refused renewal? |

**NOTE: MISSOURI APPLICANTS DO NOT RESPOND**

**If Yes**, please attach a copy of the cancellation or non-renewal notice or letter.

D Yes D No 3. Has application (new or renewal) for professional liability insurance coverage ever been accepted subject to any conditions or restrictions? **If Yes**, please attach a separate sheet containing a complete explanation.

4. Prior Insurance: List applicant's professional liability insurers in the past ten (10) years. Attach a copy of the most recent declaration page, certificates of insurance covering the past 10 years, and claims history reports for each carrier. Attach additional pages as needed.

**EXPLAIN ANY UNINSURED PERIODS.**

Insurance Carrier Coverage Dates Limits of Liability

Coverage Type (Occurrence/Claims-Made)

Claims-Made Retroactive Date

1. **EMPLOYEE/INDEPENDENT CONTRACTOR ROSTER**
   1. **Employees and independent contractors should be listed below. Please attach a separate sheet if more space is required.**

*Please note: Coverage is available to the members of your group for their work with the group, as well outside of the group. If any member of the group requires coverage for professional activities outside the group (e.g., private practice location), please indicate the number of hours practiced at this location in column five, “Outside Practice Coverage Desired?”*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NAME, DEGREE | EMPLOYEE OR INDEPENDENT CONTRACTOR (E OR IC) | SPECIALTY | # OF PATIENT CONTACT HOURS  PER WEEK WITHIN THE GROUP | OUTSIDE PRACTICE COVERAGE DESIRED? (Y OR N) | CURRENT INSURER | CURRENT LIMITS OF  LIABILITY | CURRENT TYPE OF COVERAGE: OCCURRENCE OR CLAIMS MADE  (O OR CM) | RETROACTIVE  DATE |
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# COVERAGE REQUEST:

**Desired Effective Date of Coverage:**

***NOTE: The earliest effective date we can grant, if your application is approved, is the postmark date of your submission.***

1. **Type of Coverage:**

|  |  |  |
| --- | --- | --- |
| DClaims-Made (All states)  **Requested Retroactive Date**: | D Claims-Made w/Prepaid Tail (**May not be** a**vailable in all states**) | * Occurrence\*   **(May not be available in all states**) |
| * If prior coverage was on a claims-made policy, was the Extended Reporting Period Endorsement Purchased? D Yes D No (**If yes**, please attach a copy.) * Are you requesting Prior Acts coverage? D Yes D No **If yes**, please complete the Prior Acts Coverage Supplemental Application. Additional information must be completed on the SUPPLEMENTAL APPLICATION for Kansas applicants. | | |

1. **Limits of Liability: (Additional Underwriting Guidelines may apply to selected Limits of Liability; All Limits of Liability may not be available in all states)**

$2,000,000/$6,000,000 $250,000/$750,000

$1,300,000/$3,900,000 (NY ONLY) $200,000/$600,000

$1,000,000/$3,000,000 (WI – REQUIRED LIMIT) $100,000/$300,000 (LA – REQUIRED LIMIT)

$500,000/$1,500,000 (PA – REQUIRED LIMIT)

1. **Individual limits for each professional?** D Yes D No
2. **Limits to be shared by corporation/partnership and all non-psychiatrists?** D Yes D No
3. **Type of Practice: *(check all that apply)***

D General Psychiatry

D Therapy/Counseling

D Child & Adolescent Psychiatry (Please complete the Child & Adolescent Psychiatry Supplemental Application)

D Other Psychiatric Specialty:

D Neuropsychiatry

D Neurology *– no surgery*

D Neurology with minor surgery (including but not restricted to angiograms, CAT scans, myelogram, MRI imaging, arteriograms and pneumoencephalograms)

# PRACTICE LOCATIONS:

*Please complete a section for* ***EACH*** *practice location. (Please list principal location first). Copy this page for additional locations as needed.*

**This location is a:**

1. Entity Name: Street Address: City/State/Zip: County: Telephone: Fax: Average weekly practice: (in hours):

Average number of patients per week:

D Main Practice Location D Hospital

D Secondary Practice Location D Private Office

Owned Leased

Square feet

# of floors

D Nursing Home

D Outpatient Clinic

D Government Hospital (Federal, State, Local)

D Other (Specify):

1. Do you want a Certificate of Insurance sent to this location? D Yes D No
2. Is coverage desired for professionals who provide behavior healthcare services at this location? **If no**, please indicate which professional liability insurance carrier covers these professional at this location and attach a copy of the declarations’ page to this policy.
3. Does the group maintain a commercial general liability insurance policy for this location?

D Yes D No

D Yes D No

Carrier Limits Policy coverage dates

**This location is a:**

1. Entity Name: Street Address: City/State/Zip: County: Telephone: Fax: Average weekly practice: (in hours):

Average number of patients per week:

D Main Practice Location D Hospital

D Secondary Practice Location D Private Office

Owned Leased

Square feet

# of floors

D Nursing Home

D Outpatient Clinic

D Government Hospital (Federal, State, Local)

D Other (Specify):

1. Do you want a Certificate of Insurance sent to this location? D Yes D No
2. Is coverage desired for professionals who provide behavior healthcare services at this location? **If no**, please indicate which professional liability insurance carrier covers these professional at this location and attach a copy of the declarations’ page to this policy.
3. Does the group maintain a commercial general liability insurance policy for this location?

D Yes D No

D Yes D No

Carrier Limits Policy coverage dates

1. **PRACTICE PROFILE:** *Please attach a separate sheet for any required explanations.*

1.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does any member of your group sign insurance or other reimbursement forms for patients where he/she has not participated in their care and treatment? **If yes**, please describe in what capacity (e.g., as a Medical Director) and indicate if clarification of the signature is made on the  forms: | D | Yes | D | No |
| Does each member create and maintain a psychiatric/medical record for each patient under their care?  **If no**, please explain: | D | Yes | D | No |
| Does any member of your group prescribe controlled substances? | D | Yes | D | No |
| Does each member obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics? | D | Yes | D | No |
| Does any member of your group have patients sign an arbitration agreement? | D | Yes | D | No |
| If yes, is signing a condition of treatment? | D | Yes | D | No |
| Does any member of your group write prescriptions for patients not clinically evaluated **other than to cover for another colleague** whose patient requires a minimal refill on an existing prescription. **If yes**, please explain under what circumstances: | D | Yes | D | No |
| Does any member of your group provide medication management for patients who see another professional (e.g., Ph.D., MSW) as their primary therapist and see the member for medication management only?  For how many patients per week? How often does the member see each patient? | D | Yes | D | No |
| Does any member of your group regularly treat general medical conditions presented by psychiatric patients? **If yes**, | D | Yes | D | No |

2.

3.

4.

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please indicate:

* Average number of patients per week the member provides general medical treatment to:
* Nature of the general medical conditions treated and the type of treatment provided:
  1. Does any member of your group now practice any specialty other than psychiatry/mental health?

**If yes**, check applicable specialty(ies) below and indicate % of practice:

D Yes D No

D General Practice %

D Family Practice %

Pediatrics % Other (Specify) %

* 1. Does any member of your group advertise as a specialist\* in the evaluation and treatment of any of the following? D Yes D No

D Borderline Personality Disorder D Chronic Pain D Multiple Personality Disorder or Dissociative Disorders

D Childhood Sexual Abuse D Eating Disorders D Sex Therapy

If yes, how many patients for each specialty? What percentage of his/her total patient load?

***\*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.***

* 1. Does any member of your group supervise any other psychiatrist or other mental health care providers specializing in the disorders/activities listed in #10?

|  |  |  |
| --- | --- | --- |
| D Yes | D | No |
| D Yes | D | No |
| D Yes | D | No |
| D Yes | D | No |
| D Yes | D | No |
| D Yes | D | No |
| D Yes | D | No |

* 1. Does any member of your group practice include treatment with the use of abreaction, rage, sodium amytal, sex, antiandrogen or recovered memory therapies? **If yes**, please explain the clinical details regarding this treatment.
  2. Does any member or employee of your group communicate with patients via e-mail?
     + For each member of the group that communicates with patients by email, what is the percentage of their individual patient load for which they use this method of communication? %
     + Do you or any member of your group utilize e-mail to render psychiatric services?
     + Do the patients reside in a state other than the state in which the treating physician(s) is licensed to practice? If yes, please explain.
     + Is informed consent obtained regarding at least confidentiality/privacy issues involved with email communication, the topics generally not appropriate for email, and the risks and benefits including possible clinical limitations when using email?
     + On a separate sheet, please explain the nature of communications in detail.
  3. Does your group practice include telemedicine activities, e.g., direct interaction with patients through electronic means (video, computer, or telephone) in order to provide healthcare to patients who are geographically separated from the clinicians involved?

If yes:

* + - What is the percent of the total practice time devoted to this activity?
    - While being treated, are the patients physically located outside the state or jurisdiction where your practice is located?
    - If yes, is the treating group member currently licensed to practice in the state or jurisdiction where the patient is located at the time of treatment?
    - Is the jurisdiction outside the U.S.?
    - On a separate sheet, please explain the details of the telemedicine arrangement (i.e. the location, equipment, conditions being treated, number of patients, mental health professionals and/or other resources available to the patient at his/her location, etc.)
  1. Does any member of your group engage in any clinical and/or pharmaceutical research or research involving medical devices? **If yes,** please complete the Clinical/Pharmaceutical Research Supplemental Application and submit it along with a copy of the indemnification agreement provided by the pharmaceutical company.

%

D Yes

D Yes

D Yes

D No

D No

D No

* 1. Does any member of your group treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment?

|  |  |  |  |
| --- | --- | --- | --- |
| D | Yes | D | No |
| D | Yes | D | No |
| D | Yes | D | No |
| D | Yes | D | No |
| D | Yes | D | No |
| D | Yes | D | No |

**If yes**, please describe:

* 1. Does the group or any member of your group have a website or affiliation with a website? Website Address:
  2. Does the practice of any member of your group include the use of narcotic drugs for opioid addiction treatment? If yes, please provide proof of special DEA registration or of a DATA 2000 waiver.
  3. Does any member of your group perform Brain Spect Imaging?

If yes, on a separate piece of paper, please describe the weekly patient volume and training related to this procedure.

* 1. Does any member of your group perform Vagus Nerve Stimulation therapy (VNS)? If yes:

1. Please provide evidence of completion of training for the use of VNS Therapy. If the training program is one that

***was not*** sponsored by Cyberonics, please include a brochure detailing the program.

1. Please provide an example of the informed consent form and any other materials that will be used as part of the informed consent process with patients for VNS therapy.
2. On a separate sheet of paper, please describe:
   1. the methods used to monitor patients using VNS therapy
   2. how it is determined which of your referral physicians are qualified and trained to perform the surgical procedure for implantation of the VNS pulse generator
3. Will VNS therapy be prescribed for an off-label use?

D Yes

D No

# DECLARATIONS:

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

**NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA 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 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 AUTHORITIES

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: 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 KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

**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 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.

**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.

**NOTICE TO OHIO APPLICANTS**: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: 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 (365:15- 1-10, 36 §3613.1).

**NOTICE TO OREGON 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO PENNSYLVANIA 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO VERMONT APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

## *Print Name Group Name*

***Signature Date***

***Title Tax ID Number***

If you are applying for **Group Professional Liability Insurance,** please submit the following documents with your application.

D A copy of the most recent professional liability insurance declarations’ page (facesheet) for each member of the group.

D The most recent audited financial statement for the group.

D Copies of all marketing materials used by the group.

D A copy of summary of the Quality Assurance or Quality Improvement Plan used by the group.

D If applicable, documentation of attendance at a risk management seminar for each group member.

D Loss history for each member of the group.

(This must be obtained by you from the member’s current insurer as they will not release this information to an outside party.)

D Complete a copy of Addendum I: Claims History for each claim

D Complete a copy of Addendum II: Prior Acts Coverage, for each member requesting this coverage.

*The Psychiatrists’ Program*

1515 Wilson Boulevard, Suite 800

Arlington, VA 22209

Name of Agent:

License #:

Signature:

Date:

**NOTES SECTION**

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| **Question #** |  | **Comments** |
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