

**AMERICAN HOME ASSURANCE COMPANY**

**1271 Ave of the Americas FL 37**

**New York, NY 10020-1304**

(A capital stock company, herein called the Company)

**PSYCHOANALYSTS PROFESSIONAL LIABILITY INSURANCE**

**RENEWAL APPLICATION**

**All questions must be answered completely. If answer to any question is NONE or NOT APPLICABLE, so state. The application must be signed and dated by applicant.**

**Renewal Policy Number:** \_\_\_\_\_

**Renewal Effective Date:** \_\_\_\_\_

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**I. GENERAL INFORMATION**

1. (a) Name of Applicant \_\_\_\_\_

(b) Address: \_\_\_\_\_

*No. Street. Town County State Zip Code*

*(If more than one location, list on separate sheet and attach to application)*

(c) Business Phone: ( ) \_\_\_\_\_ **No. of hours of Practice Each Week** \_\_\_\_\_  
*Area Code Number*

2. (a) Coverage Desired (Check One):

☐ Individual

☐ Partnership

☐ Professional Corporation (Incorporated as a P.C., P.A. or L.L.C.)

3. (a) Requested Limits of combined Professional and Premises Liability (Check One). (Note: These are overall limits, not separate limits for each person covered). (Limits of Liability apply to each wrongful act or series of continuous, repeated or interrelated wrongful acts or occurrence/aggregate):

☐ \$ 250,000 each incident/ \$ 750,000 annual aggregate **Indiana Residents Only**

☐ \$ 500,000 each incident/ \$1,500,000 annual aggregate **Pennsylvania Residents Only**

☐ \$1,000,000 each incident/ \$1,000,000 annual aggregate

☐ \$1,000,000 each incident/ \$3,000,000 annual aggregate

☐ \$2,000,000 each incident/ \$4,000,000 annual aggregate

☐ \$2,000,000 each incident/ \$6,000,000 annual aggregate

☐ \$3,000,000 each incident/ \$5,000,000 annual aggregate

☐ \$5,000,000 each incident/ \$5,000,000 annual aggregate

(b) Optional Coverages:

Note: Your policy may already provide lower limits of this coverage at no charge. This is an overall limit, not separate limits for each person covered.

Please check limit desired:

**Administrative  
Hearing Defense**

☐ \$10,000

☐ \$25,000

☐ \$50,000

## II. PRACTICE PROFILE

1. Procedures - Check the box next to the procedure(s) you perform:

☐ Electro-Convulsive Therapy (ECT), **if checked you must complete 2.**

☐ Group Therapy

☐ Other Somatic Procedure(s) (List specifically below) :

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

2. In the past year, have you prescribed or administered ECT?

☐ Yes ☐ No

If yes, complete the following:

- (a) Number of patients prescribed ECT in the last twelve (12) months: \_\_\_\_\_
- (b) Number of ECT treatments administered in the last twelve (12) months: \_\_\_\_\_
- (c) Estimated expected number of ECT treatments that will be administered in the next twelve (12) months: \_\_\_\_\_
- (d) Have written policy that includes criteria? ☐ Yes ☐ No
- (e) Informed consent process and written form? ☐ Yes ☐ No
- (f) Emergency equipment in immediate ECT treatment area? ☐ Yes ☐ No
- (g) A process to follow up and document post-procedure patient status? ☐ Yes ☐ No
- (h) A process in place to communicate with primary health providers? ☐ Yes ☐ No

3. In the last year, have you hired any other employees excluding clerical?

☐ Yes ☐ No

Name	Profession	Degree/Year	Licensed As	Practice With Applicant is Full Time/Part Time

4. In the last year, have there been any new (W2 Form) employed psychoanalysts and/or partners?

☐ Yes ☐ No

Name	School Graduated from/Degree(s) earned/Year earned	Specialty	License Number/Year/State	Hrs. of Practice/Week

**NOTE: General medical services greater than 5% of your practice not directly related to psychiatric or psychoanalytic care is not covered by the policy.**

5. What percentage of the applicant's practice consists of general medical activities with patients other than his or her psychiatric or neurological patients? \_\_\_\_\_%

Is the applicant engaged in the practice of psychiatry or psychoanalysis other than their own private practice?

☐ Yes ☐ No

If yes, provide name, city/state and number of above hours at facility.

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6. How many patients do you treat on an annual basis? \_\_\_\_\_

7. Do you prescribe medication to your patients as part of your treatment plans?

☐ Yes ☐ No

If Yes, what percentage of your total number of patients on an annual basis do you prescribe medication?

Percentage of Patients Prescribed Medication	Check One
0% to 5%	
6% to 25%	
26% to 40%	
41% to 50%	
Over 50%	

Do you prescribe opioids to any of your patients? ☐ Yes ☐ No

If yes, under what circumstances do you prescribe opioids? (Explain) \_\_\_\_\_

8. Have you completed a Risk Management seminar in the last twelve (12) months? ☐ Yes ☐ No  
If yes, provide a copy of your certificate of completion.

9. Are you providing any utilization review services? ☐ Yes ☐ No  
If yes, provide details. \_\_\_\_\_

10. Does your practice in any manner involve Telemedicine? ☐ Yes ☐ No  
If you provide telemedicine, do you:

- Ensure that you are properly licensed for each and every patient encounter? ☐ Yes ☐ No
- Have HIPAA compliant practices? ☐ Yes ☐ No
- Have a basic policy outlining the choice, risk and benefits on your patients' treatment method as virtual versus in-person treatments? ☐ Yes ☐ No

11. Does your practice involve electronic data or recordkeeping? ☐ Not Applicable  
If yes, do you have EACH of the following in place?

- (a) a person or group responsible for information security ☐ Yes ☐ No
- (b) a virus protection program ☐ Yes ☐ No
- (c) a firewall ☐ Yes ☐ No
- (d) a software update process, including updating patches and anti-virus software ☐ Yes ☐ No

### III. REPRESENTATION SECTION

Any policy issued by the company is based on the following representations:

**For the following questions, if you respond in the affirmative, please attach a separate sheet of paper with the details to be considered.**

1. In the last year has the narcotics license of any person named in Question 4, including yourself, ever been suspended revoked or voluntarily surrendered or has probation ever been invoked? ☐ Yes ☐ No

2. \*After Inquiry of each individual listed in Section II. Questions 3 & 4 of the practice profile.

\* "After Inquiry" means that the applicant has inquired of each person 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) In the last year, has any person named in Section II. Questions 3 & 4 of the practice profile, including yourself, ever been convicted of, or charged with, a crime in any state or country and the disposition of which was other than acquittal or dismissal. ☐ Yes ☐ No
- (b) Has your license ever been suspended, revoked, voluntarily surrendered or subject to probation in any state? ☐ Yes ☐ No
- (c) In the last year, has any person named in Section II. Questions 3 & 4 of the practice profile, including yourself, ever had any insurance company or Lloyd's syndicate decline, cancel, refuse to renew or accept only on special terms, any professional liability insurance?  
**NOTE: MISSOURI APPLICANTS DO NOT RESPOND.** ☐ Yes ☐ No
- (d) In the last year, has any professional liability claim or suit ever been made against any person named in Section II. Questions 3 & 4 or employed physician and/or partners, including yourself, their predecessors in business or against any past or present partner(s)? ☐ Yes ☐ No
- (e) In the last year, are there any circumstances of which any person named in Questions 3 & 4 of the practice profile, including yourself, is aware of which may result in any professional liability claim or suit being made against any person named in Questions 3 & 4 of the practice profile, their predecessors in business or against any past or present partner(s)? ☐ Yes ☐ No
- (f) Has applicant had a foreclosure, repossession, bankruptcy or filed for bankruptcy during the last five (5) years? ☐ Yes ☐ No

Occurrence Date	Explanation	Resolution	Resolution Date

3. If a policy is issued, please forward a Certificate of Insurance to the following entity:
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I HEREBY DECLARE THAT THE FOREGOING STATEMENTS ARE TRUE AND ACCURATE AND MAY BE RELIED UPON BY THE COMPANY/UNDERWRITER FOR PURPOSES OF ISSUING THIS COVERAGE. 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.

#### FRAUD WARNINGS

**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 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 OF THE THIRD DEGREE.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Agent's/Producer's Signature: \_\_\_\_\_

License #: \_\_\_\_\_