

AMERICAN HOME ASSURANCE COMPANY
1271 Ave of the Americas FL 37
New York, NY 10020-1304
(A capital stock company, herein called the Company)

ILLINOIS
PSYCHOANALYSTS PROFESSIONAL LIABILITY POLICY
SCHOOL/INSTITUTE/SOCIETY LIABILITY COVERAGE
APPLICATION

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

I. APPLICANT

Name: _____
(If more than one entity/subsidiary, please provide description and % owned for each)
Address: _____
Telephone: () _____ No. _____ Street _____ Town _____ County _____ State _____ Zip Code _____
Fax Number: () _____
Employer Federal Tax ID#: _____ Date Business Established: _____
Applicant Operates: ☐ For Profit ☐ Not for Profit
Total Annual Gross Receipts: \$ _____

II. COVERAGE REQUESTED

1. Desired Professional Liability Limits (Check One):
- ☐ \$100,000/\$300,000 ☐ \$1,000,000/\$1,000,000
☐ \$500,000/\$500,000 ☐ \$1,000,000/\$3,000,000
☐ Other: _____
2. Desired Premises Liability Limits (Check One):
- ☐ \$10,000/\$10,000 ☐ \$1,000,000/\$1,000,000
3. Proposed Effective Date: _____

III. UNDERWRITING PROFILE

1. Total enrollment of school: Matriculating _____
Non-Matriculating _____
2. School is licensed or certified by: _____
(Please provide use with a copy of your license if applicable)
3. Applicant is a member in good standing of the following professional associations or societies:

4. The school is affiliated with the following healthcare facilities:

5. The school employs the following number of teachers:

_____ Psychoanalysts	_____ Registered Nurses
_____ Psychiatrists	_____ Social Workers
_____ Psychologists	_____ Other

Do you have written requirements that the above listed professionals carry Professional Liability Insurance? ☐ Yes ☐ No

Please indicate limits required. _____

6. How many years does it take to complete curriculum? _____
7. Are students required to undergo personal analysis? _____
8. How many patients are each student required to treat, under supervision, per term? _____
9. How many hours of analysis are required of individual cases? _____
10. How many supervising or controlling analysts are assigned to each student on his/her cases? _____
11. How many hours are required for supervised clinical experience? _____
12. (a) Is shock therapy administered? _____
 (b) Are drugs or tranquilizers prescribed? _____
 (c) If yes to (a) or (b) above, please attach a description of procedures required.
13. Do you require all patients to sign an informed consent form? _____
14. The number of outpatient visits over the past twelve (12) months: _____

Estimated number of outpatient visits expected over the next twelve (12) months: _____

PLEASE NOTE: The following is counted as an outpatient visit:

- (a) Individual Counseling: Each face-to-face visit is considered one (1) visit.
- (b) Group Therapy: Each patient in group session therapy is to be considered one (1) visit.
- (c) ALL visits performed under the direction of the School, Institute and/or Society whether conducted on school property or in a private facility are to be included in the school's total outpatient number.

15. Professional liability insurance history (all years to present):

Insurer	Limits of Liability	Inception Date	Expiration Date	Retroactive Date

IV. CLAIMS HISTORY

1. Have any claims or suits been made within the past five years against the applicant? ☐ Yes ☐ No
 Please attach copy of insurance copy loss runs for the last five years.
2. Is the applicant aware of any circumstances which may result in any claims or suits being made against the applicant? (Including requests for medical records). ☐ Yes ☐ No
 If yes, attach explanation.
3. Has any applicant ever had any insurance company, Lloyd's Syndicate or underwriter decline, cancel, refuse to renew or accept only on special terms, any professional liability insurance? ☐ Yes ☐ No
4. 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

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.

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.

Applicant's Signature:_____

Title:_____

Date:_____

Name of Agent/Producer:_____

Date:_____

Telephone Number:_____