

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 NEW YORK

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: _____

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):

- \$1,000,000 each incident/ \$1,000,000 annual aggregate
- \$1,000,000 each incident/ \$3,000,000 annual aggregate
- \$1,300,000 each incident/ \$3,900,000 annual aggregate **New York Hospital Affiliation Only**
- \$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 these coverages at no charge. These are overall limits for each coverage, not separate limits for each person covered. Please check limit desired:

- Billing E&O
Claim Expense**
- \$25,000
 - \$50,000

- HIPAA Defense
Coverage**
- \$25,000

- 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) (Please describe) _____

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: _____

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 medicine services greater than 5% of your practice not directly related to psychiatric or psychoanalytic care is not covered by the policy.

5. New Employees experience – Check the applicable box:

<input type="checkbox"/> 2 years or less	<input type="checkbox"/> More than 5 years but less than 10 years
<input type="checkbox"/> More than 2 years but less than 5 years	<input type="checkbox"/> 10 years or more years
<input type="checkbox"/> 5 years	

6. Is the applicant a member in good standing of a Professional Association? Yes No

Applicant is a member of the following Professional Association(s): (List all) _____

7. 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.

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

9. How many patients do you treat on an annual basis? _____

10. 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) _____

11. 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.

12. Do you have documented risk management and continuing education protocols for all staff? Yes No

13. Do you maintain documentation of patient history, records and procedures? Yes No

14. Do you have documented medical emergency plan in place consistent with the components of a sound medical emergency plan for the psychoanalyst's office, as described by an authoritative healthcare organization or resource? Yes No

15. Do you conduct frequent safety inspections of all work areas or have an office safety program? Yes No

16. Are you providing any utilization review services? Yes No
If yes, provide details. _____

17. Does your practice in any manner involve Telemedicine? Yes No
If yes, provide details. _____

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? 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:

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 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.

Applicant's Signature: _____ Date: _____

Title: _____

Agent's/Producer's Signature: _____

License #: _____