

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

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. GENERAL INFORMATION

- 1. Name of Applicant: _____
- 2. Name of Professional Corporation, Partnership, Association: _____
- 3. Mailing Address: _____

- 4. Business Address: _____

- 5. Business Phone: _____
- 6. Cell Phone: _____
- 7. Email Address: _____
- 8. Fax Number: _____

II. COVERAGE REQUESTED - Please complete fully. For additional employees, please attach an additional sheet, if necessary.

- 1. Coverage Desired (Check One):
 Individual Partnership Professional Corporation (Incorporated as a P.C., P.A. or L.L.C.)
- 2. Proposed Effective Date: _____
- 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 these coverages at no charge. ~~These are~~ This is an overall limits ~~for each coverage~~, not separate limits for each person covered. Please check limit desired:

Billing E&O	HIPAA	Administrative
Claim Expense	Defense Coverage	Hearing Defense
<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$10,000
<input type="checkbox"/> \$50,000		<input type="checkbox"/> \$25,000
		<input type="checkbox"/> \$50,000

4. a) List your name and qualifications and those of all (W2 Form) employed psychoanalyst(s) and/or partners.

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

- b) The following MUST be completed for all other employees not listed in A (excluding clerical):

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

- c) Are any of the above graduates of a foreign school? Yes No

If yes, have you been certified by the educational council for Foreign Medical School Graduates? Yes No
Date _____

5. The applicant received analytic training at: _____

6. Applicant is a member in good standing of the following Professional Association(s): _____

7. 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.

III. PRACTICE SPECIALTY

1. (a) Specialty - Check the box next to those you are involved in:

- Psychoanalysis/Psychotherapy In-Patient Hospital Psychiatry Psychiatry
 Child Psychiatry Residency Neurology
 General Medicine (No surgery)

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

- (b) What percentage of the applicant's practice consists of general medical activities with patients other than his or her psychiatric or neurological patients? _____%

2. (a) Procedures - Check the box next to those you utilize:

- Electro-Convulsive Therapy (ECT), **if checked you must complete section 2b.** Group Therapy
 Other Somatic Procedures (Please describe) _____
 I do not perform any of these procedures

- (b) If you prescribe or administer ECT, please complete the following:

1. Do you prescribe ECT? Yes No
2. Do you administer ECT? Yes No

3. Number of patients prescribed ECT in the last twelve (12) months: _____
4. Number of ECT treatments administered in the last twelve (12) months: _____
5. Expected number of ECT treatments that will be administered in the next twelve (12) months:

3. Is the applicant engaged in:

- Private Practice Agency
 Hospital Clinic
 Government Teaching
 Correctional Facility
 Other (Explain) _____

4. If the applicant is engaged in areas of psychiatry or psychoanalysis other than their own private practice, please list the following information:

Name of Facility	Type of Facility	Type of Services	City/State	No. of Hours

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

6. 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) _____

7. Is any proposed insured the proprietor or owner of a hospital, sanatorium, nursing home or clinic with bed and board facilities or laboratory? Yes No

If yes, please give full details:

(Note: The policy does not cover liability as proprietor or owner of the above facilities.)

8. Are any of the applicants or persons named in Section II, Question 4, acting as an administrator of a hospital, sanatorium, nursing home, clinic or laboratory? Yes No

If yes, please give full description of job duties:

(Note: Managerial or Administrative functions are not covered.)

IV. UNDERWRITING PROFILE

1. *After Inquiry of each individual listed in Section II, Question 4. *"After Inquiry" means that the applicant has inquired of each person as 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.

Has the narcotics license of any person named in Section II, Question 4., including yourself, ever been suspended, revoked or voluntarily surrendered or has probation ever been invoked?

Yes No

If yes, please give full particulars in order for your application to be considered.

a. Your narcotics license number: _____

b. Your D.E.A. license number: _____

2. *After Inquiry of each individual listed in Section II, Question 4. *"After Inquiry" means that the applicant has inquired of each person as 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.

Has any person named in Section II, Question 4, including yourself, ever been convicted of, or charged with a crime in any state or country, the disposition of which was other than acquittal or dismissal?

Yes No

If yes, please give full particulars in order for your application to be considered.

3. Has your professional liability insurance ever been canceled, declined, non-renewed, or accepted only on special terms? **NOTE: MISSOURI APPLICANTS DO NOT RESPOND**

Yes No

If yes, provide details: _____

4. Has your medical or narcotics license ever been suspended, revoked, voluntarily surrendered, or subject to probation in any state?

Yes No

If yes, provide details: _____

5. Have you ever had any licensing board or professional ethics body ever require you to surrender your license or found you guilty of violations of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?

Yes No

If yes, please provide details: _____

6. Have you ever:

a. Been convicted for violation of any law or ordinance other than minor traffic offenses?

Yes No

b. Been treated for alcoholism or drug addiction?

Yes No

c. Had any chronic illness or physical defect that affected your ability to practice psychoanalysis?

Yes No

d. Had any hospital privileges suspended or revoked?

Yes No

e. Had practicing privileges with an HMO, PPO, or other managed care facility suspended or revoked?

Yes No

If you answered yes to any of the above questions, please explain on separate sheet.

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

Insurer	Limits of Liability	Inception Date	Expiration Date	Retroactive Date

8. If a policy is issued, please forward a Certificate of Insurance to the following entity: _____

V. PRACTICE PROFILE

1. List hospitals where you have privileges (list by name of hospital, city and state): **Joint Commission Accredited**
 _____ Yes No
 _____ Yes No
 _____ Yes No

2. List any HMO or PPO memberships: _____

3. Please list any other physicians you assist, practice in conjunction with or are in any other way associated with and explain your relationship.

Name	Relationship
_____	_____
_____	_____
_____	_____

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

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

6. Do you consult, teach or train outside your practice? Yes No
 If yes, provide details: _____

7. 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) a virus protection program | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) a firewall | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) a software update process, including updating patches and anti-virus software | <input type="checkbox"/> Yes <input type="checkbox"/> No |

VI. CLAIMS HISTORY

1. Has any professional liability claim or suit ever been made against you, your predecessors in business or against any past or present partner(s) Yes No
 If yes, please provide details on the claim supplement form attached. Use separate form for each claim.

2. Are there any circumstances of which you are aware that may result in any professional liability claim or suit being made against you, your predecessors in business or against any past or present partner(s)? Yes No
 If yes, please provide details on a separate sheet. Please use one sheet for each incidence.

3. Have any professional liability claims or suits been made or brought against any of your employees or any member, stockholder or partner of your professional association, professional corporation or partnership? Yes No
 If yes, provide details: _____

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

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.

~~FOR MAINE APPLICANTS ONLY: THE UNDERSIGNED DECLARES TO THE BEST OF HIS OR HER KNOWLEDGE THAT THE STATEMENTS SET FORTH HEREIN ARE ACCURATE, TRUE AND COMPLETE. 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.~~

~~FOR UTAH APPLICANTS ONLY: THE APPLICATION AND ALL RELEVANT DOCUMENTS WILL BE ATTACHED TO THE POLICY AT THE TIME OF DELIVERY.~~

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 ALABAMA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION, FINES, OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.~~

~~**NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND, 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 CALIFORNIA APPLICANTS:** FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE 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 AGENCIES.~~

~~**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 OF THE THIRD DEGREE.

~~**NOTICE TO KANSAS APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE THAT SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.~~

~~**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 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 OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR 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 MEXICO 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 CIVIL FINES AND CRIMINAL 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.~~

~~**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, MAY BE GUILTY OF 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.~~

Applicant's Signature: _____ Date: _____

Title: _____

Producer's Signature: _____

License #: _____