

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
MARYLAND
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. Office 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):
 - \$1,000,000 each incident/ \$1,000,000 annual aggregate
 - \$2,000,000 each incident/ \$6,000,000 annual aggregate
 - \$1,000,000 each incident/ \$3,000,000 annual aggregate
 - \$3,000,000 each incident/ \$5,000,000 annual aggregate
 - \$2,000,000 each incident/ \$4,000,000 annual aggregate
 - \$5,000,000 each incident/ \$5,000,000 annual aggregate

(b) Optional Coverages:

Note: These are overall limits for each coverage, not separate limits for each person covered.

Please check limit desired:

Billing E&O Claim Expense (Claims Expense Aggregate)	HIPAA Defense Coverage (Aggregate)	Administrative Hearing Defense (Each Administrative Hearing/ Aggregate Administrative Hearing)
<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$50,000		<input type="checkbox"/> \$10,000
		<input type="checkbox"/> \$25,000
		<input type="checkbox"/> \$50,000

(c) Optional Deductible

Please check deductible desired:

\$25,000

\$50,000

\$100,000

3. 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
- Hospital
- Government
- Correctional Facility
- Other (Explain) _____
- Agency
- Clinic
- Teaching

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? 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 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

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.

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 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.

Applicant's Signature: _____ Date: _____

Title: _____

Producer's Signature: _____

Underwritten by: AMERICAN HOME ASSURANCE COMPANY