AMERICAN HOME ASSURANCE COMPANY

175 Water Street, 18th Floor, New York, NY 10038

(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:

No. Street Town County State Zip Code

Telephone: ( ) 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):

$200,000/$600,000 $1,000,000/$1,000,000

$500,000/$500,000 $1,000,000/$3,000,000

Other:

1. 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

1. School is licensed or certified by:

(Please provide use with a copy of your license if applicable)

1. Applicant is a member in good standing of the following professional associations or societies:

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

1. 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.

1. How many years does it take to complete curriculum?
2. Are students required to undergo personal analysis?
3. How many patients are each student required to treat, under supervision, per term?
4. How many hours of analysis are required of individual cases?
5. How many supervising or controlling analysts are assigned to each student on his/her cases?
6. How many hours are required for supervised clinical experience?
7. (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.

1. Do you require all patients to sign an informed consent form?
2. 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:

1. Individual Counseling: Each face-to-face visit is considered one (1) visit.
2. Group Therapy: Each patient in group session therapy is to be considered one (1) visit.
3. 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.
4. 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.

1. Is the applicant aware of any circumstances which may result in any claims or suits Yes No

being made against the applicant? (Including requests for medical records).

If yes, attach explanation.

1. 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?

**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.

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, 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, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

Applicant's Signature:

Title:

Date:

Name of Agent/Producer:

Date:

Telephone Number: