# AMERICAN HOME ASSURANCE COMPANY

**Administrative Offices: 175 Water Street, 18th Floor, New York, NY 10038**

(A capital stock company, herein called the Company)

# PSYCHOANALYSTS PROFESSIONAL LIABILITY INSURANCE ALASKA RENEWAL APPLICATION

## 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:**

1. **GENERAL INFORMATION**
2. (a) Name of Applicant
   1. Address:

*No. Street. Town County State Zip Code (If more than one location, list on separate sheet and attach to application)*

* 1. Business Phone: ( ) **No. of hours of Practice Each Week**

*Area Code Number*

1. (a) Coverage Desired (Check One):

* Individual
* Partnership
* Professional Corporation (Incorporated as a P.C., P.A. or L.L.C.)

1. 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

$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

## 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:

1. Number of patients prescribed ECT in the last twelve (12) months:
2. Number of ECT treatments administered in the last twelve (12) months:
3. Estimated expected number of ECT treatments that will be administered in the next twelve (12) months:
   1. In the last year, have you hired any other employees excluding clerical?  Yes  No

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| --- | --- | --- | --- | --- |
| **Name** | **Profession** | **Degree/Year** | **Licensed As** | **Practice With Applicant is Full Time/Part Time** |
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* 1. In the last year, have there been any new (W2 Form) employed psychoanalysts and/or partners?  Yes  No

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| --- | --- | --- | --- | --- |
| **Name** | **School Graduated from/Degree(s) earned/Year earned** | **Specialty** | **License Number/Year/State** | **Hrs. of Practice/ Week** |
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## NOTE: General medical services not directly related to psychiatric or psychoanalytic care is not covered by the policy.

* 1. 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.

* 1. 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.
  2. Are you providing any utilization review services?  Yes  No

If yes, provide details.

* 1. Does your practice in any manner involve Telemedicine?  Yes  No

If yes, provide details.

* 1. Do you have EACH of the following in place?

1. a person or group responsible for information security  Yes  No
2. a virus protection program  Yes  No
3. a firewall  Yes  No
4. a software update process, including updating patches and anti-virus software  Yes  No
   1. Has Applicant experienced any loss that would be covered under this policy in the past 3 years?  Yes  No

If yes, include date, type and amount of loss:

## 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.

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\* “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.

1. 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

1. Has your license ever been suspended, revoked, voluntarily surrendered or subject to

probation in any state?  Yes  No

1. 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
2. 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

1. 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

* 1. 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.

**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.

Applicant's Signature: Date:

Title:

Producer’s Signature:

Florida License #:

## Please make check payable and mail to:

**FRENKEL & COMPANY**

601 Plaza 3, 6th Floor Harborside Financial Center Jersey City, NJ 07311

Tel.: (201) 356-3400

Fax: (201) 356-3463

## Toll Free (800) 373-6535

Underwritten by: AMERICAN HOME ASSURANCE COMPANY