Risk Placement Services, Inc.
PO Box 834
Poulsbo WA 98370

SOCIAL SERVICE AND HEALTHCARE PROFESSIONAL LIABILITY APPLICATION

☐ **THIS APPLICATION IS ON AN OCCURRENCE COVERAGE BASIS.**

☐ **THIS APPLICATION IS ON A CLAIMS-MADE COVERAGE BASIS.**

NOTICE: THIS APPLICATION IS FOR A COVERAGE PART WRITTEN ON A CLAIMS-MADE BASIS. "CLAIMS" MUST BE FIRST MADE AGAINST ANY INSURED DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD, AND REPORTED TO US AS SOON AS PRACTICABLE DURING THE POLICY PERIOD, ANY SUBSEQUENT RENEWAL OF THE POLICY OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE INSURANCE FOR WHICH THIS APPLICATION IS MADE APPLIES ONLY IF THE "WRONGFUL ACT" OUT OF WHICH THE "CLAIM" AROSE OCCURRED ON OR AFTER THE RETROACTIVE DATE, IF ANY, SHOWN IN THE DECLARATIONS AND BEFORE THE END OF THE POLICY PERIOD.

Please answer all questions completely. If there is insufficient space to complete an answer, please continue on a separate sheet indicating the question number. This Application must be completed, signed, and dated by an officer, director or equivalent executive of the Organization. Please include all attachments referenced throughout the Application and complete any supplemental applications referenced within the Application. Please type or print.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Insurer under any Policy of a Claim or potential Claim. All such notices must be submitted to the Insurer pursuant to the terms of the Policy, if and when issued.

All questions must be completed to enable us to provide you with a quote. Please include any brochures or descriptive materials that may assist us in a better understanding of your agency.

I. YOUR AGENCY

1.The precise name of your agency including any "D/B/A's" _____

☐ For Profit ☐ Non-Profit ☐ Other; Describe _____

2.Your mailing address: _____

City and State _____ Zip_____

Effective Date of Coverage:_____ Webpage address:_____

Please provide the addresses of all locations owned/leased by the insured to be covered:

	STREET ADDRESS	CITY AND STATE	ZIP CODE	OCCUPANCY/EXPOSURE
(1)				
(2)				
(3)				

(4) _____

3. Please provide a brief description of your operations.

_____

_____

_____

4. How long has your agency been in operation? _____ What is your annual budget? _____
   a. Name all subsidiary companies/locations and other operations within applicant's control. _____
   _____
   b. Has applicant sold, acquired or discontinued any operations in the last 5 years? If yes, explain. _____
   _____
5. Please give a complete percentage breakdown of your funding sources (total to equal 100%).
   _____
6. Are you aware of any state, federal, local code or professional ethics violations by your agency or any of your employees? ☐ Yes ☐ No
7. Are you licensed by the state(s) in which you operate? ☐ Yes ☐ No If No, is a license required? _____
   (Please attach a copy of license and latest inspection)
   If yes, is it renewed ☐ annually ☐ semi-annually ☐ other _____
   Has your license ever been suspended or revoked? ☐ Yes ☐ No
   If yes, please give details. _____
8. Provide the following information:
   a. Is a complete background investigation required for all staff? ☐ Yes ☐ No
   b. Do you verify employment related references? ☐ Yes ☐ No
   c. Do you verify educational requirements? ☐ Yes ☐ No
   d. Do you conduct a personal interview? ☐ Yes ☐ No
   e. Are licenses checked for employees/volunteers, when appropriate? ☐ Yes ☐ No

   f. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients? ☐ Yes ☐ No
   g. Do you have a crisis management plan for dealing with staff, victim, parents, authorities and media if you have an incident of abuse? ☐ Yes ☐ No
   h. Do you maintain training programs for your staff? ☐ Yes ☐ No
      If yes, are they mandatory? ☐ Yes ☐ No
      Describe training offered _____

II. YOUR OPERATIONS

9. PLEASE CHECK **YES** or **NO** TO THE SERVICE (S) BELOW THAT BEST DESCRIBE YOUR OPERATION. *Check all that apply.*
   a. **RESIDENTIAL CARE:** Do you operate any Residential Facilities? ☐ Yes ☐ No
   (If "Yes", please complete a Residential Facility Questionnaire MP4004c for each facility.)
   b. **FOSTER CARE/ADOPTION PLACEMENT SERVICES:** ☐ Yes ☐ No
   (If "Yes", please complete attached Foster/Adoption Placement Supplement MP4004b.)

   c. **OUTPATIENT SERVICES:**

YES	NO		# Clients(annual)	#of Days No.
☐	☐	Drug & Alcohol Treatment: Individual	_____	_____

☐	☐	Drug & Alcohol Classes (DUI/DWI)	_____	_____
☐	☐	Mental Health Counseling: Individual	_____	_____
☐	☐	Mental Health Counseling: Group	_____	_____
☐	☐	MR Treatment Center	_____	_____
☐	☐	Cerebral Palsy Center	_____	_____
☐	☐	Rehabilitation Agency	_____	_____
☐	☐	Case Management (MH/MR/Comm. Support)	_____	_____
☐	☐	Training	_____	_____
☐	☐	Hospice (outpatient)	_____	_____
☐	☐	Family Skills Training	_____	_____
☐	☐	Referral Agency	_____	_____
☐	☐	Day Schools	_____	_____
☐	☐	Home Studies	_____	_____
☐	☐	CASA(Court Appointed Special Advocates)	_____	_____
☐	☐	Advocacy Services	_____	_____
☐	☐	Independent Living Skills Training	_____	_____
☐	☐	Before & After School Care	_____	_____
☐	☐	Headstart Program	_____	_____
☐	☐	Day Camps for Mentally Ill or Developmentally Disabled	_____	_____
☐	☐	Day Care for Mentally Ill or Dev. Dis. Sheltered Workshop/Work Activity	_____	_____
☐	☐	Recreation Program	_____	_____
☐	☐	*Agencies for Aging/Senior Citizens	_____	_____

d. ☐ ☐ Home Care _____ Home Health Care _____Respite Care _____Loc # _____

Age Range of Clients (*please enter the number of clients in each age group*):

Level of Care: Developmentally Disabled 0-17 _____ 18-60 _____ 60+ _____

Mentally Impaired 0-17 _____ 18-60 _____ 60+ _____

Other 0-17 _____ 18-60 _____ 60+ _____

Please describe services provided_____

_____

e. ☐ ☐ Methadone Maintenance Clinic No. of Licensed Slots: _____Loc No. _____

f. ☐ ☐ Meals on Wheels No. of Meals Annually: _____ Loc No. _____

g. ☐ ☐ Hotline Center No. of Calls Annually: _____ Loc No. _____

h. ☐ ☐ Mentorship No. of Matches:_____How often do they meet?_____

i. ☐ ☐ Other Services not described above; Include # of Client Contacts/Appointments annually

_____ Loc No. _____

10. **STAFF**	**Employees**		**Non-Employees (Volunteers/Consultants)**	
	No. Full time	**No. Part Time**	**No. Full time**	**No. Part Time**
RN'S/LPN'S	_____	_____	_____	_____
CNA/Caregivers	_____	_____	_____	_____
Physicians Assts.	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____
Social Workers	_____	_____	_____	_____
Residence Managers	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Physicians	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
Psychiatrist	_____	_____	_____	_____

Occupational Therapist	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Personal Trainer	_____	_____	_____	_____
Health /Fitness Instructor	_____	_____	_____	_____
Nutritionist/Dietician	_____	_____	_____	_____
Others (specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Include any Medical Director(s) in appropriate class)

11. Total Number of Staff:_____ Ratio of Staff to Clients:_____(staff) to _____(clients)
    Annual Staff turnover rate:_____%

12. Does your staff include any of the following types of professionals?
    - Accountant ☐ Yes ☐ No If yes, how many?_____
    - Attorney ☐ Yes ☐ No If yes, how many?_____
    - Architect ☐ Yes ☐ No If yes, how many?_____
    - Engineer ☐ Yes ☐ No If yes, how many?_____
    - Financial Advisor/Consultant ☐ Yes ☐ No If yes, how many?_____

    If you would like coverage for these individuals please complete the appropriate Supplemental Miscellaneous Professional Application.

13. Do you handle clients' money, bills or finances of any type?
    If yes, please give details(what is handled and what controls are in place). _____
    _____

14. Are any of your facilities in operation 24 hours? ☐ Yes ☐ No. If yes, is there a supervisor on duty 24 hours? ☐ Yes ☐ No

III. MEDICAL STAFF & PROCEDURES

15. Do you have any employed, volunteer or contracted Physicians/Psychiatrists serving your organization?
    ☐ Yes ☐ No Do you want coverage for these Physicians and Psychiatrists? ☐ Yes ☐ No
    (If Yes, complete the Licensed Practitioner of the Healing Arts Supplemental Application for each professional.,MP4004a)
16. Do you provide any primary medical or skilled nursing services? ☐ Yes ☐ No If yes, please explain.
    _____
17. Do you or any of your staff prescribe or administer any medications? ☐ Yes ☐ No If yes, **please provide a list** on a separate sheet of paper of the medications, who prescribes them, for what purpose, and how they are secured.
18. Do you have Policies & Procedures in place for prescribing/administering medication? ☐ Yes ☐ No
    Are non-FDA approved drugs prescribed or administered? ☐ Yes ☐ No
19. Are you involved in any of the following; Clinical Trials, pharmaceutical testing or research ☐ Yes ☐ No
    If yes, please describe: _____
20. Does a physician screen client prior to admission? ☐ Yes ☐ No If no, please describe procedure which determines who is eligible for admission: _____
    _____
21. Are Patients physically restrained? ☐ Yes ☐ No
22. Do you have facilities for surgery, x-rays, or other medical treatment? ☐ Yes ☐ No
    If yes, please describe: _____
23. Do you contract with any other facilities for additional beds? ☐ Yes ☐ No If yes, please indicate the number or estimated number of beds and provide a copy of the contract. No. of Contracted beds_____
24. Does your agency recommend release, parole or incarceration of clients? ☐ Yes ☐ No

(If yes, please explain on a separate sheet of paper.)

25. Do you treat any sexual offenders? ☐ Yes ☐ No
(If yes, please explain on a separate sheet of paper.)

26. Do you service clients recently released from a lock-up facility? ☐ Yes ☐ No
(Describe the nature of offenses on a separate sheet of paper.)

IV. ADDITIONAL INSUREDS (PROFESSIONAL LIABILITY)

Insurable Interest - Check box that applies

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address: _____ Describe: _____
_____

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address: _____ Describe: _____
_____

Name: _____ ☐ Funding/Grant ☐ Contract/Services ☐ Other
Address: _____ Describe: _____
_____
_____

V. YOUR INSURANCE HISTORY

LINE	COMPANY	LIMITS	PREMIUM	DED	EFFECTIVE/ EXPIRATION DATE	RETROACTIVE DATE
Professional Liability						

27. If you have not purchased coverage before, please explain. _____
_____

28. Is your expiring professional liability coverage on a claims made basis? ☐ Yes ☐ No
If yes, would you like us to include prior acts coverage? ☐ Yes ☐ No
If yes, please provide proof of uninterrupted claims made coverage since the retroactive date requested.

29. Has any carrier cancelled or refused coverage for your agency? ☐ Yes ☐ No
(THIS QUESTION DOES NOT APPLY TO APPLICANTS IN MISSOURI)
If yes, please explain. _____

VI. CLAIM INFORMATION

30. Have you had any claims and/or circumstances that have not been previously reported? ☐ Yes ☐ No
If yes, please attach detailed claim information with the date of the loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.
Please attach 5 years loss history for your professional liability coverage.

31. Please describe your procedures when reporting potential incidents to the proper authorities. _____
_____

NOTICE TO APPLICANT – PLEASE READ CAREFULLY

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED, AS AUTHORIZED AGENT FOR ALL PERSONS AND ENTITIES PROPOSED FOR THIS INSURANCE, DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO ISSUE, OR THE APPLICANT TO PURCHASE, ANY

INSURANCE POLICY.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER. IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE COVERAGE PART, THE APPLICANT MUST NOTIFY THE INSURER, WHO MAY MODIFY OR WITHDRAW THE QUOTATION.

THE UNDERSIGNED, AS THE AUTHORIZED REPRESENTATIVE OF THE INSURED ACKNOWLEDGES THAT THEY HAVE BEEN ADVISED THAT:

A. IF THE CLAIMS-MADE COVERAGE BASIS BOX IS SELECTED, THIS POLICY APPLIES ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF EXERCISED.

(WORDS WITHIN QUOTATION MARKS ARE DEFINED IN THE INSURANCE COVERAGE FORM.)

FRAUD STATEMENT

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.

FRAUD STATEMENT 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.

FRAUD STATEMENT TO ARKANSAS 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.

FRAUD STATEMENT 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 settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT TO LOUISIANA 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT TO MARYLAND APPLICANTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT 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.

FRAUD STATEMENT TO OREGON APPLICANTS

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT 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.

FRAUD STATEMENT TO RHODE ISLAND 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, including failing to disclose whether the applicant or applicants have been convicted of any degree of the crime of arson, is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT TO TENNESSEE 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.

FRAUD STATEMENT TO VERMONT 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 may be a crime and subjects such person to criminal and civil penalties.

FRAUD STATEMENT TO VIRGINIA 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.

FRAUD STATEMENT TO 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.

FRAUD STATEMENT TO 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.

_____ _____/_____/_____
Signature of Applicant Date

_____
Name and Title

This application form duly completed, together with any supplementary information must be signed in ink by the applicant

_____ _____ _____
Please Print Name Signature of Producer submitting Date Signed

Producing Agency : _____

Address: _____

_____

Telephone: ( ) _____

Did you remember to?

If you have Physicians on staff and are requesting Physicians coverage :

☐ Complete the **Licensed Practitioner of the Healing Arts Supplemental Application for each professional.** to be named on the policy

If you are a Foster Care or Adoption Agency :

☐ Complete the Foster Care and Adoption Care Supplement

If you have a Residential/Respite/Daycare Facility:

☐ Complete the Residential Facility Supplement

If you have a Vocational or Sheltered Workshop :

☐ Complete the Vocational/Sheltered workshop Supplement

If you have specific Professionals on staff and are requesting Miscellaneous Professional coverage:

☐ Complete the appropriate Miscellaneous Professional Liability application for the professionals identified in Question 15 of this application.

If you are applying for Sexual Abuse or Molestation coverage:

☐ Complete the appropriate Sexual Abuse Or Molestation Liability application .

General Reminders:

☐ Did you complete each question in all applicable sections as we cannot offer a quote based on incomplete information?

☐ Did you sign and date all applications?

☐ Did you attach current loss runs?