

NEGLEY
ASSOCIATES
INSURANCE SERVICES

103 Eisenhower Parkway, Suite 101, Roseland, NJ 07068
1-800-845-1209 • (973)830-8500 • Fax: (973)830-8585
www.jjnegley.com

**Professional & General Liability
Insurance Application**

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**APPLICATION FOR
PROFESSIONAL AND GENERAL LIABILITY COVERAGE**

For this application to be processed in a timely fashion, please answer every question completely. If a question is not applicable, please write N/A. Do not leave any space blank.

1. Name of Insured _____

2. Mailing Address:

Street _____ County _____

City _____ Phone # _____

State _____ Zip _____ Fax # _____

Website _____ Contact _____

3. Type of Organization: Individual _____ Corporation, for profit _____
Partnership _____ Corporation, nonprofit _____
Trust _____ Limited Liability Company (LLC) _____

4. Describe the purpose of the organization (attach brochures)

5. If more than one Named Insured is listed above, please explain the ownership and operational relationships.

6. Number of years in operation _____

7. Has any license or accreditation ever been suspended, denied or revoked? _____

8. Of what professional association(s) is the Insured a member in good standing?

9. Projected annual operating budget \$ _____ **Include current Audited Financial Statement.**

10. Current Insurance:

Professional Liability

General Liability

Company _____

Company _____

Inception Date: _____ Expiration Date: _____

Inception Date: _____ Expiration Date: _____

Premium \$ _____

Premium \$ _____

Deductible \$ _____

Deductible \$ _____

Limit of Liability \$ _____

Limit of Liability \$ _____

Occurrence Form? _____ or Claims Made? _____

Occurrence Form? _____ or Claims Made? _____

If Claims Made form, Retroactive Date _____

If Claims Made form, Retroactive Date _____

11. Limits Requested: Professional Liability \$ _____ General Liability \$ _____

12. Has any company cancelled or declined to renew insurance? _____
 If yes, please explain. _____

13. Have there been any claims or lawsuits in the last five years? Yes No

Date of Loss Amount Paid or Reserved Claimant's Name/Description of Claim (Attach separate sheet if necessary)

_____	_____	_____
_____	_____	_____
_____	_____	_____

14. Are there any circumstances known which may give rise to a claim or lawsuit? Yes No If yes, explain. (Attach separate sheet if necessary)

It is understood that with respect to Questions 13 & 14 above, any claim or action arising out of such facts, circumstances or situations is excluded from the proposed coverage.

15. Schedule of Employees:

	Full Time	Number of Part Time	Volunteer
Administrators	_____	_____	_____
Case Managers	_____	_____	_____
Clerical	_____	_____	_____
Counselors	_____	_____	_____
Homemakers/Aides	_____	_____	_____
Nurses (LPN)	_____	_____	_____
Nurses (RN)	_____	_____	_____
Nurse Practitioners	_____	_____	_____
Psychologists	_____	_____	_____
Physician Assistants	_____	_____	_____
Social Workers	_____	_____	_____
Students	_____	_____	_____
Others, please specify _____	_____	_____	_____

16. Schedule of Physician Staff (Employed, Contracted or Volunteer) if none, write "none" _____.

Name	Specialty	Board Certified	Board Eligible	Hours/Week Worked	Employed, Contracted or Volunteer (E, C or V)	Carries own Malpractice Insurance	
						Yes	No
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

17. Do you wish physicians to be covered under the Center's policy? Yes No

18. Are drugs or medication administered or prescribed? Yes No If yes, please explain.

19. Is electroshock therapy utilized? Yes No If yes, how many per year? _____

20. Schedule of Locations: (Attach separate sheet if necessary.)

Loc. No.	Complete Address (including zip code)	Sq. Feet	Type of Services Provided
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

21. List of Additional Insureds: (If none, write "none" _____) (Attach separate sheet if necessary.)

Name and Address (including zip code)	Interest
_____	_____
_____	_____
_____	_____

22. Units of Service – Please indicate the number of units of each service rendered by the facility, where appropriate:

Licensed Bed Capacity:

Mental Health Inpatient	_____	Group Home	_____
Alcohol/Drug Inpatient	_____	Shelters	_____
Alcohol/Drug Detox	_____	Independent Living	_____
Halfway House	_____	Foster Care	_____
		Other, please specify	_____

Annual Outpatient or Client Visits:

Alcohol/Drug Rehab	_____	Counseling	_____
Mental Health	_____	Other, please specify	_____

Clients per Day:

Adult Day Care	_____	Day Treatment	_____
Child Day Care	_____	Sheltered Workshops	_____
Case Management	_____	Other, please specify	_____

Annual Calls:

Hotline	_____	Information	_____
Referral	_____	Other, please specify	_____

Annual Employee Assistance Programs (EAP) Contacts or Visits:

Assessments	_____	Counseling Visits	_____
Referrals	_____	No. of Companies under Contract	_____

Home Health Care Visits:

Nonprofessional Hours	_____	IV Therapy	_____
Professional Hours	_____	Other, please specify	_____

Miscellaneous:

Mentor Matches	_____	Annual Methadone doses	_____
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Attach an application supplement for Residential or Inpatient, Day Care, Pre-School, Headstart, Methadone/Buprenorphine, Foster Care/Adoption, Sheltered Workshops/Products, if applicable.

23. Are there any camp, adventure/wilderness, ropes courses, or any type of recreational programs? If yes, please provide descriptive material. _____

24. Are there any swimming or boating activities? If yes, please provide details. _____

Very Important — Please attach copies of all available descriptive materials and/or brochures on your operations.

This application does not bind you nor us to complete the insurance, but it is agreed this form will be the basis of the contract should a policy be issued. This form will be attached to and become a part of this policy.

FRAUD WARNING: 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.

SIGNATURE: _____ TITLE: _____
(Must be signed by the Executive Director)

(Please print or type name)

Please retain a copy of the completed application. A copy with the required signature must be returned to our office.

PRODUCER: Will you make the Surplus Lines filing for this policy? Yes No

Your Surplus Lines License Number _____ ()

NOTICE:

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: www.insurance.ca.gov.**
- 5. FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
- 6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER’S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Date: _____

Insured: _____