

**NEGLEY**  
**ASSOCIATES**  
UNDERWRITING MANAGERS

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

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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)

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*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.

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

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

Loc. #	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 camps, 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.

This insurance contract is with an insurer not licensed to transact insurance in this state and is issued and delivered as a surplus line coverage under the Texas insurance statutes. The Texas Department of Insurance does not audit the finances or review the solvency of the surplus lines insurer providing this coverage, and this insurer is not a member of the property and casualty insurance guaranty association created under Article 21.28-C, Insurance Code. Section 12, Article 1.14-2, Insurance Code, requires payment of 4.85 percent tax on gross premium.

**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)

\_\_\_\_\_ DATE: \_\_\_\_\_

(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 \_\_\_\_\_( )