Social Workers Professional and Office Liability Insurance

Program Administrator:

AMERICAN PROFESSIONAL AGENCY, INC.

95 Broadway, Amityville, New York 11701

(631) 691-6400 • (800) 421-6694 (x2308)

www.AmericanProfessional.com

New Hampshire Insurance Company
American Home Assurance Company
Granite State Insurance Company
c/o: American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

FOR OFFICE USE ONLY
PREMIUM:
RATED BY:
EFFECTIVE DATE:
RETRO DATE:
REFUND AMOUNT DUE:

Application

for Social Workers Professional Liability Insurance

PLEASE COMPLETE EVERY QUESTION FULLY

Notice to Florida Applicants:
Florida License #054346502 issued to Richard C. Imbert

Notice to California Applicants:
California License #0555091 issued to American Professional Agency, Inc.

NOTICE: THIS IS A CLAIMS-MADE FORM: EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED HEREIN, THE COVERAGE OF THIS POLICY IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE COMPANY WHILE THE POLICY IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE THE SPECIAL PROVISION "SEXUAL MISCONDUCT" IN THE POLICY).

1. (a) Name of Applicant: _____

(b) Coverage desired (check one):

☐ Individual ☐ Partnership ☐ Professional Corporation (Incorporated as a P.C. or P.A.) ☐ LLC

☐ General Business Corporation _____ Profit _____ Nonprofit ☐ Other (Please explain) _____
(If you are unsure of your corporate status, please check your articles of incorporation.)

(c) **If you have checked anything other than individual the following MUST BE INCLUDED: a letter describing all services provided, include any brochures if available, and a listing of owners and/or partners, indicating the percentage owned by each.**

2. Mailing Address: _____ Bus. Phone # - ( ) _____
area code number

_____
(city) (county) (state) (zip code)

E-mail Address: _____

3. (a) Limits of Liability desired (check one): (Limits of Liability apply to: each wrongful act or series of continuous, repeated or interrelated wrongful acts or occurrence / aggregate.)

☐ $1,000,000/1,000,000 ☐ $1,000,000/3,000,000 ☐ $1,000,000/4,000,000
☐ $1,000,000/5,000,000 ☐ $2,000,000/2,000,000 ☐ $2,000,000/4,000,000

(b) Prior Acts coverage ☐ Yes ☐ No Retroactive Date Desired _____
(See information regarding eligibility for prior acts under "Coverage and Eligibility".)

4. **List Your Name** and **ALL** your credentials. In addition, list the names and **ALL** credentials of all your salaried (W2 form) employees, except clerical. If you are applying for a partnership policy, please list all partners as well. Please include the premium charge indicated on the rate schedule for yourself and each employee and/or partner.

Name	NASW Membership Number	Academic Degree(s)	Field of Study	Date Degree Received mm/yy	College or University Degree Received From	Please check the appropriate box(es): Academy of Certified Social Workers	Member of NASW	Full title of your license or certification and the field of practice and state in which you hold it.

Please complete the application on the next page.

Please complete every question fully.

5. Please list the number of people on your entire employed staff (except clerical) including yourself. _____
Note: Your staff is defined as your direct employees (for whom you file a W2 form) and their names and credentials must be included with yours under Question 4 to correspond with the number listed here.

6. (a) Are you engaged in self-employment, paid consultation, private practice or volunteer work? ☐ Yes ☐ No

(b) If you answered yes to question 6 (a), have you obtained your ACSW (Academy of Certified Social Workers) certification from the NASW or completed two years of supervised agency/organizational clinical social work that was supervised by a professional who holds a minimum of a Masters Degree in the mental health field? ☐ Yes ☐ No

(c) Are you employed (W2 form employee)? ☐ Yes ☐ No

If yes, employed by: _____

(d) ☐ I understand that if I apply and qualify for the exclusively employed rate, the policy will exclude coverage for private practice, self-employment, consulting, volunteering or social work outside the course of employment.

(e) If your highest degree is a BSW, or if you are a New Graduate and First Time Practitioner, the following information must be included with your application and payment for review of acceptability:

1. Name and address of your employer: _____
2. Tax form issued - 1099 or W2: _____
3. The name of your supervisor: _____
4. Supervisor's degree, field of study, license and / or certification: _____

7. Are you or any person named in Question 4 a salaried employee of any organization other than the applicant's firm or do you own, partly own, manage or exercise any form of fiduciary control over any business enterprise? ☐ Yes ☐ No

If yes, please explain: _____

8. Has any person named in Question 4 ever had professional liability coverage? ☐ Yes ☐ No

If yes, please list:

Name of Carrier: _____ Limits of Liability: _____

Premium: _____ Expiration Date: _____ Retro Date: _____

Policy Type: ☐ Claims-Made ☐ Occurrence

If you checked off claims-made, please check the appropriate box below:

( ) I have purchased the extended reporting period endorsement on my prior policy.

Name of carrier: _____

( ) I have elected to take Prior Acts Coverage and completed Question 3b of this application.
I realize that unless I purchase Prior Acts Coverage which coincides with the retroactive date of my previous claims-made policy and have no extended reporting period endorsement that I will have a gap in coverage.

( ) **I understand that I elected not to purchase the Extended Reporting Period Endorsement on my previous claims-made policy, and I also have elected not to purchase Prior Acts Coverage on my new claims-made policy. I understand that I will be uninsured for the period in which my prior claims-made policies existed. Furthermore, I understand that because of this there will be a gap in my insurance coverage.**

9. (a) Does the applicant use any Independent Contractors or Consultants (1099 form) whose services are in the mental health field and for whom you do billing for, share fees with or in any way derive income from the relationship? ☐ Yes ☐ No

(b) If yes, please list the names and professional credentials of each one.

The Independent Contractor (1099 form) charge shown on the rate schedule must be included for each Contractor or Consultant listed and added to your premium. **YOU WILL BE COVERED FOR THEIR ACTS, SUBJECT TO THE TERMS OF THE POLICY, BUT THE INDEPENDENT CONTRACTORS OR CONSULTANTS LISTED ARE NOT INSURED.**

Name of Independent Contractor or Consultant	Degree	Field of Study	License or Certification	
			State	Title

If additional space is required, please use a separate sheet of paper to submit a complete listing.

Please complete the application on the next page.

Please complete every question fully.

REPRESENTATION SECTION

Any policy issued by the Company is based on the following Representations:

10. *After inquiry of each individual listed in Question 4:
*"After inquiry" means that the applicant has inquired of each person as 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.**

(a) Has any person named in Question 4, including yourself, ever been convicted of a crime in any state or country, the disposition of which was other than acquittal or dismissal? ☐ Yes ☐ No

If yes, please give full particulars in order for your application to be considered.

_____

_____

_____

(b) Has any person named in Question 4, including yourself, ever been required by any licensing board or professional ethics body to surrender your license or found you guilty of a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country (including alternative dispute resolution cases)? ☐ Yes ☐ No

If yes, please give full particulars, and copies of charges, correspondence and any findings in order for your application to be considered.

_____

_____

_____

(c) Are there any complaints, charges or investigations pending against any person named in Question 4, including yourself, by any licensing board or professional ethics body for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country (including alternative dispute resolution cases)? ☐ Yes ☐ No

If yes, please give full particulars, and copies of charges, correspondence and any findings in order for your application to be considered.

_____

_____

_____

(d) Has any person named in Question 4, including yourself, ever had any insurance company or Lloyd's decline, cancel, refuse to renew or accept only on special terms any professional liability insurance? **(NOTE: MISSOURI APPLICANTS DO NOT RESPOND.)** ☐ Yes ☐ No

If yes, please give full particulars in order for your application to be considered.

_____

_____

_____

(e) Has any professional liability claim or suit ever been made against any person named in Question 4, including yourself, their predecessors in business or against any past or present partner(s)? ☐ Yes ☐ No

If yes, please give full particulars and copies of any summons and complaints, pertinent correspondence and outcome, if any, in order for your application to be considered.

_____

_____

_____

Question 10 continued on the next page.

Please complete every question fully.

(f) Are there any circumstances of which any person named in Question 4, including yourself, is aware of that may result in any professional liability claim or suit being made against any person named in Question 4, their predecessors in business or against any past or present partner(s)? ☐ Yes ☐ No

If yes, please give full particulars in order for your application to be considered.

_____

_____

_____

(g) Is any person named in Question 4, including yourself, engaged in or ever been engaged in any sexual misconduct with any current or former patients or any current or former patient's spouse or any person with a direct relationship to the patient or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)? ☐ Yes ☐ No

(Sexual misconduct means any actual or alleged erotic physical contact or attempt thereat or proposal thereof.)

If yes, please give full particulars in order for your application to be considered.

_____

_____

_____

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION BY APPLICANT CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT NOR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

Notice 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."

Notice 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 a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

Notice 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 in the third degree."

Notice 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."

Notice 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 denial of insurance benefits."

Notice to Minnesota Applicants: "Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

Notice 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."

Notice 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."

Notice 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."

Notice 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."

Notice 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."

I understand that it is my obligation to maintain any license required in the jurisdiction(s) in which I practice.

Date: _____ Signature: _____
(APPLICANT/OWNER/PRESIDENT OF CORPORATION)

Title: _____

Application must be signed, dated, fully completed and accompanied by the premium to be considered. **Please make checks payable and return with the application to: American Professional Agency, Inc., 95 Broadway, Amityville, NY 11701**

Signature of Authorized Representative of the American Professional Agency, Inc.: _____

ANNUAL PREMIUM RATE SCHEDULE

NOTE: There is a surcharge for those who reside in Kentucky, West Virginia, or New Jersey. Please contact the American Professional Agency, Inc. for the additional charge at 800-421-6694 or visit our website at www.AmericanProfessional.com. There are additional forms to complete if you reside in Arkansas, Kansas, or Minnesota. Please contact the American Professional Agency, Inc. for these forms at 800-421-6694.

PLEASE USE THIS SCHEDULE WHEN COMPUTING YOUR PREMIUM

A. First Year Rate - NO PRIOR ACTS
(Coverage begins on the effective date of the policy)

	INDIVIDUAL - PARTNERSHIP						CORPORATION - LLC - P.C. - P.A.			
Limits of Liability	(1) Individual or Partner BSW MSW	(2) Part-time or Exclusively Employed	(2a) New Graduate Who is a First Time Practitioner	(3) Professional (W2 form)	(4) Para-professional (W2 form)	(5) Your Independent Contractors or Consultants (1099 form)	(6) Corporation LLC, P.A. or P.C.	(7) Owner, Member or Professional (W2 form)	(8) Para-professional (W2 form)	(9) Independent Contractors or Consultants (1099 form)
$1,000,000/1,000,000	$59.00	$38.00	$36.00	$59.00	$40.00	$22.00	$77.00	$59.00	$40.00	$22.00
$1,000,000/3,000,000	$67.00	$44.00	$40.00	$67.00	$45.00	$25.00	$87.00	$67.00	$45.00	$25.00
$1,000,000/4,000,000	$69.00	$45.00	$42.00	$69.00	$46.00	$26.00	$90.00	$69.00	$46.00	$26.00
$1,000,000/5,000,000	$71.00	$46.00	$43.00	$71.00	$48.00	$26.00	$93.00	$71.00	$48.00	$26.00
$2,000,000/2,000,000	$69.00	$45.00	$41.00	$69.00	$46.00	$26.00	$90.00	$69.00	$46.00	$26.00
$2,000,000/4,000,000	$71.00	$46.00	$43.00	$71.00	$48.00	$26.00	$93.00	$71.00	$48.00	$26.00

B. Second Year Rate - ONE YEAR PRIOR ACTS
(You will be covered for any act, error or omission that occurred up to one year prior to the effective date of the policy and otherwise covered by the policy.)

	INDIVIDUAL - PARTNERSHIP						CORPORATION - LLC - P.C. - P.A.			
Limits of Liability	(1) Individual or Partner BSW MSW	(2) Part-time or Exclusively Employed	(2a) New Graduate Who is a First Time Practitioner	(3) Professional (W2 form)	(4) Para-professional (W2 form)	(5) Your Independent Contractors or Consultants (1099 form)	(6) Corporation LLC, P.A. or P.C.	(7) Owner, Member or Professional (W2 form)	(8) Para-professional (W2 form)	(9) Independent Contractors or Consultants (1099 form)
$1,000,000/1,000,000	$102.00	$67.00	$62.00	$102.00	$70.00	$22.00	$133.00	$102.00	$70.00	$22.00
$1,000,000/3,000,000	$116.00	$76.00	$71.00	$116.00	$79.00	$25.00	$151.00	$116.00	$79.00	$25.00
$1,000,000/4,000,000	$120.00	$78.00	$73.00	$120.00	$82.00	$26.00	$156.00	$120.00	$82.00	$26.00
$1,000,000/5,000,000	$124.00	$80.00	$75.00	$124.00	$84.00	$26.00	$161.00	$124.00	$84.00	$26.00
$2,000,000/2,000,000	$119.00	$78.00	$72.00	$119.00	$81.00	$26.00	$155.00	$119.00	$81.00	$26.00
$2,000,000/4,000,000	$123.00	$80.00	$75.00	$123.00	$84.00	$26.00	$160.00	$123.00	$84.00	$26.00

C. Third Year Rate - TWO YEARS PRIOR ACTS
(You will be covered for any act, error or omission that occurred up to two years prior to the effective date of the policy and otherwise covered by the policy.)

	INDIVIDUAL - PARTNERSHIP					CORPORATION - LLC - P.C. - P.A.			
Limits of Liability	(1) Individual or Partner BSW MSW	(2) Part-time or Exclusively Employed	(3) Professional (W2 form)	(4) Para-professional (W2 form)	(5) Your Independent Contractors or Consultants (1099 form)	(6) Corporation LLC, P.A. or P.C.	(7) Owner, Member or Professional (W2 form)	(8) Para-professional (W2 form)	(9) Independent Contractors or Consultants (1099 form)
$1,000,000/1,000,000	$133.00	$87.00	$133.00	$90.00	$22.00	$173.00	$133.00	$90.00	$22.00
$1,000,000/3,000,000	$151.00	$99.00	$151.00	$102.00	$25.00	$197.00	$151.00	$102.00	$25.00
$1,000,000/4,000,000	$156.00	$102.00	$156.00	$106.00	$26.00	$203.00	$156.00	$106.00	$26.00
$1,000,000/5,000,000	$161.00	$105.00	$161.00	$109.00	$26.00	$209.00	$161.00	$109.00	$26.00
$2,000,000/2,000,000	$155.00	$102.00	$155.00	$105.00	$26.00	$202.00	$155.00	$105.00	$26.00
$2,000,000/4,000,000	$160.00	$105.00	$160.00	$109.00	$26.00	$208.00	$160.00	$109.00	$26.00

D. Fourth Year Rate - THREE YEARS PRIOR ACTS
(You will be covered for any act, error or omission that occurred up to three years prior to the effective date of the policy and otherwise covered by the policy.)

	INDIVIDUAL - PARTNERSHIP					CORPORATION - LLC - P.C. - P.A.			
Limits of Liability	(1) Individual or Partner BSW MSW	(2) Part-time or Exclusively Employed	(3) Professional (W2 form)	(4) Para-professional (W2 form)	(5) Your Independent Contractors or Consultants (1099 form)	(6) Corporation LLC, P.A. or P.C.	(7) Owner, Member or Professional (W2 form)	(8) Para-professional (W2 form)	(9) Independent Contractors or Consultants (1099 form)
$1,000,000/1,000,000	$152.00	$99.00	$152.00	$102.00	$22.00	$198.00	$152.00	$102.00	$22.00
$1,000,000/3,000,000	$173.00	$113.00	$173.00	$116.00	$25.00	$225.00	$173.00	$116.00	$25.00
$1,000,000/4,000,000	$179.00	$116.00	$179.00	$120.00	$26.00	$232.00	$179.00	$120.00	$26.00
$1,000,000/5,000,000	$184.00	$120.00	$184.00	$123.00	$26.00	$239.00	$184.00	$123.00	$26.00
$2,000,000/2,000,000	$177.00	$115.00	$177.00	$119.00	$26.00	$231.00	$177.00	$119.00	$26.00
$2,000,000/4,000,000	$184.00	$119.00	$184.00	$123.00	$26.00	$239.00	$184.00	$123.00	$26.00

E. Fifth Year Rate - FOUR YEARS PRIOR ACTS
(You will be covered for any act, error or omission that occurred up to four years prior to the effective date of the policy and otherwise covered by the policy.)

	INDIVIDUAL - PARTNERSHIP					CORPORATION - LLC - P.C. - P.A.			
Limits of Liability	(1) Individual or Partner BSW MSW	(2) Part-time or Exclusively Employed	(3) Professional (W2 form)	(4) Para-professional (W2 form)	(5) Your Independent Contractors or Consultants (1099 form)	(6) Corporation LLC, P.A. or P.C.	(7) Owner, Member or Professional (W2 form)	(8) Para-professional (W2 form)	(9) Independent Contractors or Consultants (1099 form)
$1,000,000/1,000,000	$170.00	$111.00	$170.00	$114.00	$22.00	$221.00	$170.00	$114.00	$22.00
$1,000,000/3,000,000	$193.00	$126.00	$193.00	$129.00	$25.00	$250.00	$193.00	$129.00	$25.00
$1,000,000/4,000,000	$200.00	$130.00	$200.00	$134.00	$26.00	$259.00	$200.00	$134.00	$26.00
$1,000,000/5,000,000	$206.00	$134.00	$206.00	$138.00	$26.00	$266.00	$206.00	$138.00	$26.00
$2,000,000/2,000,000	$198.00	$129.00	$198.00	$133.00	$26.00	$257.00	$198.00	$133.00	$26.00
$2,000,000/4,000,000	$205.00	$134.00	$205.00	$137.00	$26.00	$266.00	$205.00	$137.00	$26.00

F Sixth Year Rate -
(Depending on your retroactive date, you will be covered for any act, error or omission that occurred after the retroactive date of the policy and otherwise covered by the policy.)

	INDIVIDUAL - PARTNERSHIP					CORPORATION - LLC - P.C. - P.A.			
Limits of Liability	(1) Individual or Partner BSW MSW	(2) Part-time or Exclusively Employed	(3) Professional (W2 form)	(4) Para-professional (W2 form)	(5) Your Independent Contractors or Consultants (1099 form)	(6) Corporation LLC, P.A. or P.C.	(7) Owner, Member or Professional (W2 form)	(8) Para-professional (W2 form)	(9) Independent Contractors or Consultants (1099 form)
$1,000,000/1,000,000	$186.00	$121.00	$186.00	$126.00	$22.00	$243.00	$186.00	$126.00	$22.00
$1,000,000/3,000,000	$212.00	$138.00	$212.00	$143.00	$25.00	$276.00	$212.00	$143.00	$25.00
$1,000,000/4,000,000	$219.00	$142.00	$219.00	$147.00	$26.00	$285.00	$219.00	$147.00	$26.00
$1,000,000/5,000,000	$225.00	$147.00	$225.00	$152.00	$26.00	$293.00	$225.00	$152.00	$26.00
$2,000,000/2,000,000	$217.00	$141.00	$217.00	$146.00	$26.00	$283.00	$217.00	$146.00	$26.00
$2,000,000/4,000,000	$225.00	$146.00	$225.00	$151.00	$26.00	$292.00	$225.00	$151.00	$26.00

PREMIUM TO INCREASE LIMITS OF LIABILITY FOR DEFENSE COSTS FOR LICENSING BOARD HEARINGS:
(Limit of $5,000 included at no extra charge.) Please complete the Addendum to Application if you are interested in higher limits for Defense Cost for Licensing Board Hearings.

ADDITIONAL INSUREDS:
An additional insured may be added to your policy for an additional premium of 20% of your annual premium. Please complete the request for an additional insured section of the Addendum to Application and return it with your completed application and premium.

Please make check payable and mail to:

American Professional Agency, Inc.
95 Broadway
Amityville, NY 11701

Addendum to Application

PLEASE COMPLETE THE ADDENDUM TO APPLICATION *ONLY* IF YOU ARE REQUESTING THE ADDITIONAL COVERAGE OFFERED.

PART-TIME DISCOUNT WORKSHEET

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND RETURNED WITH YOUR APPLICATION ONLY IF YOU ARE APPLYING FOR THE PART-TIME RATE. FAILURE TO ANSWER ALL QUESTIONS WILL RESULT IN YOUR APPLICATION BEING RETURNED.

Name of Applicant: _____

1. Practice as a sole practitioner seeing patients. This would include private practice, paid consultation (working as an independent contractor), supervision and volunteer work. _____
2. Practice as a W2 form employee. _____
3. Supervision of students seeing patients. Time spent teaching does not need to be included, however, if you have indicated on your application that you are working at a College/ University, please state the number of hours of clinical practice performed there. _____
4. Do you own or partly own a Corporation, Partnership or LLC that provides mental health services? _____Yes _____No
   If yes, you do not qualify for the part-time rate

TOTAL WEEKLY HOURS: _____

PLEASE COMPLETE THE ADDENDUM TO APPLICATION *ONLY* IF YOU ARE REQUESTING THE ADDITIONAL COVERAGE OFFERED.

Name of Applicant: _____

REQUEST FOR ADDITIONAL LIMITS FOR DEFENSE REIMBURSEMENT FOR LICENSING BOARD HEARINGS

I am interested in obtaining limits of: $25,000 $50,000 for defense reimbursement for licensing board hearings.

Limit of Defense Cost Coverage for Licensing Board Hearings	Premium Charge
$25,000	$50.00
$50,000	$75.00

I am not aware of any act, error or omission, which might reasonably be expected to give rise to a complaint to a licensing board or governmental regulatory body.

_____ _____

Signature Date

REQUEST FOR ADDITIONAL INSUREDS

(See Rate Schedule for additional charge.)

1. Name and Address of proposed Additional Insured: _____
   _____
2. Name of proposed Additional Insured's Business: _____
3. The Additional Insured is my:
   Employer Landlord Professional Corporation Other (specify): _____
4. The Additional Insured gives me the following form to file with the IRS:
   W-2 1099 Other (specify): _____
5. Describe the relationship between you and the proposed Additional Insured: _____
   _____
6. Are you requesting that the entity named in Question #1 be added as an Additional Insured in order to fulfill a contractual obligation? Yes No
   If yes, give full particulars: _____

_____ _____

Signature Date

EXPLANATION OF PREMIUM CHARGES

INDIVIDUAL OR PARTNERSHIP POLICY

(1) **Individual Insured**: If you are applying for individual coverage, this is the premium charge for you if you do not qualify for the part-time, exclusively employed or new graduate discounted rates. Your name and credentials must be listed under Question 4 of the application.
Partners – If you are a legal and binding partnership including a **Limited Liability Partnership (LLP),** this is the premium charge for each partner or member. Your name and credentials must be listed under Question 4 of the application.

(2) **Part-Time Insured** : If you are engaged in the practice of social work for 20 hours or less a week (including W2 employment and/or volunteering) and are not in a partnership, are not a member of a LLC and do not own a corporation, this is the premium charge for you. Your name and credentials must be listed under Question 4 of the application. An endorsement will be placed on your policy limiting your coverage based on the qualification listed above.
Exclusively Employed : If you are working as a **W2 form employee only,** this is the premium charge for you. You would not qualify if you own the corporation where you are working or if you are a member of a LLC. Your name and credentials must be listed under Question 4 of the application and Question 5D must be checked acknowledging that an endorsement will be placed on your policy limiting your coverage based on the qualification listed above.

(2a) **New Graduate Who Is A First Time Practitioner**: If you meet the following qualifications this is the premium charge for you: 1- You have graduated in the last year with either a BSW or MSW from an approved Social Work program. And 2- You are entering the profession of Social Work (paid or volunteer) for the first time and will have direct supervision of a qualified professional. This rate will apply to your first two years following graduation. In your third post-graduate year Rate C will apply. Your name and credentials must be listed under Question 4 of the application.

(3) **Professional Employee**: Each of your employees (W2 form) with a Master's or higher in the mental health field would be charged this premium. Their names and credentials must be listed under Question 4 of the application.

(4) **Paraprofessional Employee**: Each of your employees (W2 form) who do not qualify under the professional employee category other than clerical would be charged this premium. Their names and credentials must be listed under Question 4 of the application.

(5) **Independent Contractor or Consultant**: This is an exposure charge made for each 1099-form contractor or consultant you pay whose services are in the mental health field. The Independent Contractor or Consultant is NOT COVERED. Their names and credentials must be listed under Question 9 of the application.

LIMITED LIABILITY COMPANY (LLC), PROFESSIONAL CORPORATION (PC/PA) AND CORPORATIONS

(6) **Corporation**: This is the entity charge assessed when applying for Corporate coverage.
Professional Corporation or Professional Association: An entity charge is made if there is more than one owner (other than husband and wife), there are employees (professional and/or paraprofessional) or if the services of more than 3 independent contractors or consultants are used.
The entity charge is waived for a PC or PA with only one owner that has no employees or who use the services of 3 or less independent contractors.
Limited Liability Company: An entity charge is made if there is more than one member (other than husband and wife), there are employees (professional and/or paraprofessional) or if the services of more than 3 independent contractors or consultants are used.
The entity charge is waived for a LLC with only one member that has no employees or who use the services of 3 or less independent contractors.

(7) **Owner, Member or Professional**: This is the charge made for any owner, member or professional employee. An employee (W2 form) with a Master's or higher in the mental health field would be charged this premium. Their names and credentials must be listed under Question 4 of the application.

(8) **Paraprofessional Employee**: An employee (W2 form) who does not qualify under the professional employee category other than clerical would be charged this premium. Their names and credentials must be listed under Question 4 of the application.

(9) **Independent Contractor or Consultant**: This is an exposure charge made for each 1099-form contractor or consultant you pay whose services are in the mental health field. The Independent Contractor or Consultant is NOT COVERED. Their names and credentials must be listed under Question 9 of the application.

THE $5.00 PURCHASING GROUP FEE MUST BE ADDED TO THE TOTAL PREMIUM YOU SUBMIT.

Note: It is your obligation to notify us of any changes that occur during the policy period that may impact your coverage.

Please mail to: American Professional Agency, Inc.

Program Administrator:

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Underwritten By:
AMERICAN HOME ASSURANCE COMPANY
GRANITE STATE INSURANCE COMPANY
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