

# NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

## The Psychiatrists' Program

### *The APA-endorsed Psychiatrists' Professional Liability Insurance Program*

### Group Pre-Qualification Information

#### INSTRUCTIONS:

- ✓ Carefully review and answer **each** of the following questions.
- ✓ If you answer "YES" to any question, please provide a detailed written explanation and attach copies of all pertinent official documentation.
- ✓ If you answer "No" to all of the questions, **you have been pre-qualified for coverage**. Continue with completion of the application.
- ✓ If you answer "Yes" to any of the questions, please complete the remainder of the application. The application will be underwritten. The underwriter will contact you within 5-10 business days from the date the application is received in our office.

*Please sign and return this questionnaire with completed application. All applications are subject to underwriting approval.*

- Yes     No    Has any member of your group had their license to practice medicine denied, revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms?
- Yes     No    Has any member of your group had their license to prescribe controlled substances denied, revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms?
- Yes     No    Has any member of your group been diagnosed with any physical or mental condition that impairs their ability to practice medicine?
- Yes     No    Has any member of your group ever experienced any dependency upon alcohol, narcotics, or other drugs?
- Yes     No    Has any member of your group had an application (new or renewal) for hospital privileges denied, suspended, or accepted subject to conditions and restrictions?
- Yes     No    Has any member of your group been the subject of an investigation or disciplinary proceedings by any governmental agency (e.g., State Medical Board, DEA, HHS), professional society (e.g., APA or its District Branches) or a professional review board of a hospital, HMO, PPO, or IPA? Or, are you aware of any incident that could lead to such action? (Please provide updated information for any previously reported incidences.)
- Yes     No    Has any member of your group been charged with, convicted of, pleaded guilty or no contest to a felony?
- Yes     No    Has any member of your group ever been, or currently, either sexually, romantically, or socially involved with any current, or former, patient or with a family member of a patient?
- Yes     No    Has the group or any member of your group ever had a settlement or judgment alleging undue familiarity, professional misconduct, or assault in connection with undue familiarity?
- Yes     No    Has the group or any member of the group reported any malpractice claims or incidents to any carrier **other than** the APA-endorsed Psychiatrists Professional Liability Insurance Program in the past seven years?
- Yes     No    Is the group or any member of the group aware of any incidents, occurrences, accidents, conduct, or circumstances that are likely to give rise to a claim or suit known to you or which should have been known to you on the date of this application?
- Yes     No    Does your group or any member of your group communicate with patients via e-mail? Please explain nature of communications in detail.
- Yes     No    Does your group or any member of your group have a website, or have an affiliation with a website?

**Website address:** \_\_\_\_\_

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Group Application

IMPORTANT INSTRUCTIONS:

- Applications must be fully completed prior to submission and include all applicable supplemental applications.
All questions must be answered fully and completely. If any question does not apply to you, state N/A. Please use additional sheets to give complete answers where necessary.
This is only an application. No coverage exists until a policy is issued in your name.

A. GENERAL INFORMATION: (Please type or print)

1. Full Name of Applicant Group:
2. Contact Person: First Middle Last
3. Mailing Address: Street City/State/Zip
4. Phone: Fax: E-Mail: Website:
5. Administration: Medical Director: Quality Assurance/Improvement Dir: Chief Financial Officer: Risk Management:

B. OWNERSHIP STRUCTURE:

Corporation: Date and State of Incorporation Name of Majority Shareholder
Partnership: Date and State of Incorporation Name of Majority Shareholder
Other:

C. INSURANCE AND PROFESSIONAL HISTORY:

- Has the applicant ever been denied professional liability insurance coverage? NOTE: MISSOURI APPLICANTS DO NOT RESPOND
Has professional liability insurance coverage ever been cancelled or refused renewal? NOTE: MISSOURI APPLICANTS DO NOT RESPOND
Has application (new or renewal) for professional liability insurance coverage ever been accepted subject to any conditions or restrictions? If Yes, please attach a separate sheet containing a complete explanation.

4. Prior Insurance: List applicant's professional liability insurers in the past ten (10) years. Attach additional pages as needed.

Table with 4 columns: Insurance Carrier, Policy Period, Limits of Liability, Coverage Type (Occurrence/Claims-Made)

**D. COVERAGE REQUEST:**

Desired Effective Date of Coverage: \_\_\_\_\_

**NOTE:** *The earliest effective date we can grant, if your application is approved, is the postmark date of your submission.*

**1. Type of Coverage:**

- Occurrence\* (All states except: AK, AZ, CA DC, FL, LA, MD, MI, MN, OH, PA, SD, TX, VA, WV)
- Modified Occurrence\* (AZ, CA, DC, MD, VA Only)
- Claims-Made w/Prepaid Tail\* (AK, FL, MN, OH, SD, WV Only)
- Claims-Made Requested Retroactive Date : \_\_\_\_\_ (All states)

**2. Limits of Liability: (Additional Underwriting Guidelines may apply to selected Limits of Liability)**

- \$2,000,000/\$6,000,000 (All states except: KS, LA, PA, WI)  \$500,000/\$1,500,000 (PA ONLY)
- \$1,000,000/\$3,000,000 (All states except: KS, LA, PA)  \$200,000/\$600,000 (KS, SC, TX3 ONLY)
- \$500,000/\$1,500,000 (All states except: KS, NJ, LA, PA, WI)  \$100,000/\$300,000 (LA ONLY)
- \$1,300,000/\$3,900,000 (NY ONLY)  \$250,000/\$750,000 (IN ONLY)

**3. Type of Practice: (check all that apply)**

- Therapy/Counseling
- Psychiatry
- Neurology without procedures
- Neurology with procedures (including but not restricted to angiograms, CAT scans, myelogram, MRI imaging, arteriograms and pneumoencephalograms).

**4. Individual limits for each professional?**  Yes  No

**5. Limits to be shared by corporation/partnership and all non-psychiatrists?**  Yes  No

**NOTE:** *Additional information must be completed on the SUPPLEMENTAL APPLICATION for the following states: **KS and NY.***

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

- Extended Reporting Period Endorsement purchased on prior policy. Name of carrier: \_\_\_\_\_
- We understand that we elected not to purchase the Extended Reporting Period Endorsement on the previous claims-made policy, and we also have elected not to purchase the Prior Acts Coverage on our new policy. We understand that we will be uninsured for the period in which our prior claims-made policy existed. Furthermore, we understand that because of this there will be a gap in our insurance coverage.

**E. COVERAGE REQUESTED:**

**1. Employees and independent contractors should be listed below. Please attach a separate sheet if more space is required.**

*Please note: Coverage is available to the members of your group for their work with the group, as well outside of the group. If any member of the group requires coverage for professional activities outside the group (e.g., private practice location), please indicate the number of hours practiced at this location in column five, "Other Practice Coverage Desired?"*

| NAME, DEGREE | EMPLOYEE OR INDEPENDENT CONTRACTOR (E OR IC) | SPECIALTY | # OF PATIENT CONTACT HOURS PER WEEK WITHIN THE GROUP | OUTSIDE PRACTICE COVERAGE DESIRED? (Y OR N) | CURRENT INSURER | CURRENT LIMITS OF LIABILITY | CURRENT TYPE OF COVERAGE: OCCURRENCE OR CLAIMS MADE (O OR CM) | RETROACTIVE DATE |
|--------------|--|-----------|--|---|-----------------|-----------------------------|---|------------------|
|              |  |           |  |   |                 |                             |   |                  |
|              |  |           |  |   |                 |                             |   |                  |
|              |  |           |  |   |                 |                             |   |                  |
|              |  |           |  |   |                 |                             |   |                  |
|              |  |           |  |   |                 |                             |   |                  |
|              |  |           |  |   |                 |                             |   |                  |
|              |  |           |  |   |                 |                             |   |                  |
|              |  |           |  |   |                 |                             |   |                  |

**F. PRACTICE LOCATIONS:**

Please complete a section for **EACH** practice location. Copy this page for additional locations as needed.

|  |
|--|
| 1. Entity Name: _____                      |
| Street Address: _____                      |
| City/State/Zip: _____                      |
| County: _____                              |
| Telephone: _____ Fax: _____                |
| Average weekly practice: (in hours): _____ |
| Average number of patients per week: _____ |

**This location is a:**

- |  |  |
|--|--|
| <input type="checkbox"/> Main Practice Location      | <input type="checkbox"/> For-Profit Hospital, Clinic or Nursing Home     |
| <input type="checkbox"/> Secondary Practice Location | <input type="checkbox"/> Not-For-Profit Hospital, Clinic or Nursing Home |
| <input type="checkbox"/> Owned                       | <input type="checkbox"/> Government Hospital (Federal, State, Local)     |
| <input type="checkbox"/> Leased                      | <input type="checkbox"/> Other (Specify): _____                          |
| <input type="checkbox"/> Square feet _____           | _____  |
| <input type="checkbox"/> # of floors _____           |  |

- a) Do you want a Certificate of Insurance sent to this location?  Yes  No
- b) Is coverage desired for professionals who provide behavior healthcare services at this location? If no, please indicate which professional liability insurance carrier covers these professional at this location and attach a copy of the declarations' page to this policy.  Yes  No
- c) Does the group maintain a commercial general liability insurance policy for this location?  Yes  No
- Carrier \_\_\_\_\_ Limits \_\_\_\_\_ Policy coverage dates \_\_\_\_\_

**G. PRACTICE PROFILE:** Please attach a separate sheet for any required explanations.

1. Does any member of your group sign insurance or other reimbursement forms for patients where he/she has not participated in their care and treatment? **If yes**, please describe in what capacity (e.g., as a Medical Director) and indicate if clarification of the signature is made on the forms: \_\_\_\_\_  Yes  No
2. Does each member create and maintain a psychiatric/medical record for each patient under their care? **If no**, please explain: \_\_\_\_\_  Yes  No
3. Does any member of your group prescribe controlled substances?  Yes  No
4. Does each member obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics?  Yes  No
5. Does any member of your group write prescriptions for patients not clinically evaluated other than to cover for another colleague whose patient requires a minimal refill on an existing prescription. **If yes**, please explain under what circumstances: \_\_\_\_\_  Yes  No
6. Does any member of your group provide medication management for patients who see another professional (e.g., Ph.D., MSW) as their primary therapist and see the member for medication management only? For how many patients per week? \_\_\_\_\_ Does the member periodically see the patient?  Yes  No  Yes  No
7. Does any member of your group regularly treat general medical conditions presented by psychiatric patients? **If yes**, please indicate:  Yes  No
- Average number of patients per week: \_\_\_\_\_
  - Nature of the general medical conditions treated and the type of treatment provided: \_\_\_\_\_
8. Does any member of your group now practice any specialty other than psychiatry/mental health? **If yes**, check applicable specialty(ies) below and indicate % of practice:  Yes  No
- |   |  |
|---|--|
| <input type="checkbox"/> General Practice % _____ | <input type="checkbox"/> Pediatrics % _____      |
| <input type="checkbox"/> Family Practice % _____  | <input type="checkbox"/> Other (Specify) % _____ |
9. Does any member of your group advertise as a specialist\* in the evaluation and treatment of any of the following?  Yes  No
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Chronic Pain     | <input type="checkbox"/> Multiple Personality Disorder or Dissociative Disorders |
| <input type="checkbox"/> Childhood Sexual Abuse          | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Sex Therapy   |
- \*Note: "Specialist" is indicated by 1) advertisements, 2) marketing materials, 3) letterhead, or 4) employment, contractual relationship or admitting privileges at any institution with a special interest in any of the above.

10. Does any member of your group supervise any other psychiatrist or other mental health care providers specializing in the disorders/activities listed in #9?  Yes  No
11. Does any member of your group practice include treatment with the use of abreaction, rage, sodium amytal, sex or recovered memory therapies? **If yes**, please explain the clinical details regarding this treatment.  Yes  No
12. Does any member or employee of your group communicate with patients via e-mail? Please explain nature of communications in detail.  Yes  No
13. Does your group practice include telemedicine activities, e.g., the transfer of data through electronic (video or computer) means in order to provide healthcare to patients who are geographically separated from the clinicians involved?  Yes  No
- What is the percent of total practice time devoted to this activity? \_\_\_\_\_%
  - On a separate sheet, please explain the exact type of telemedicine.
14. Does any member of your group engage in any clinical and/or pharmaceutical research?  Yes  No
- **If yes**, does the sponsor agree in writing to indemnify for such research activities?  Yes  No
  - **If no**, please explain type and extent of such activities: \_\_\_\_\_  
\_\_\_\_\_
15. Does any member of your group treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment?  Yes  No  
**If yes**, please describe: \_\_\_\_\_

**H. DECLARATIONS:**

I hereby represent that all statements and answers on this questionnaire and any additional information attached are full, complete and true to the best of my knowledge and that insurance will be issued in reliance upon such statements and answers. I also understand that the information I have provided will be used to determine the scope of my coverage and the premiums I will pay for this coverage.

I authorize any hospital, government agency, business, partnership, professional corporation, professional association or organization, or any individual person that may have any knowledge of the information I have provided on this application and attachments to convey such knowledge to the APA – endorsed Psychiatrists Professional Liability Insurance Program (“PLIP”). A photocopy of this authorization will be sufficient for this purpose. I agree to notify the PLIP in writing within 30 days of any changes in my practice as shown on this application and any attachments. I further agree to be bound by the terms and conditions set forth in the insurance policies issued to the PLIP.

I authorize the Psychiatrists’ Purchasing Group, Inc. (“PPG”) to act on my behalf with respect to the procurement of the insurance coverage provided pursuant to the PLIP and to take such steps with respect to the acceptance and/or declination of available coverages as the PPG in its discretion shall deem to be in the best interests of the PLIP. I understand and agree that any material misrepresentation or omission by me in this application and attachments may act to void my coverage and may give the PLIP a right to rescind such coverage.

I further acknowledge and understand that all Members of the PLIP also have access to consultation on issues related to malpractice exposure. This service is provided as a risk management measure by the Program with no additional expense to the Member.

**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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ARKANSAS AND 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 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 AUTHORITIES

**NOTICE 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.

**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 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.

**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 A DENIAL OF INSURANCE BENEFITS.

**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 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 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 (365:15-1-10, 36 §3613.1).

**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.

**NOTICE TO TENNESSEE AND 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.

|                   |                      |
|-------------------|----------------------|
| _____             | _____                |
| <i>Print Name</i> | <i>Group Name</i>    |
| _____             | _____                |
| <i>Signature</i>  | <i>Date</i>          |
| _____             | _____                |
| <i>Title</i>      | <i>Tax ID Number</i> |

If you are applying for **Group Professional Liability Insurance**, please submit the following documents with your application.

- A copy of the professional liability insurance declarations' page (facesheet) for each member of the group.
- The most recent audited financial statement for the group.
- Copies of all marketing materials used by the group.
- A copy of summary of the Quality Assurance or Quality Improvement Plan used by the group.
- If applicable, documentation of attendance at a risk management seminar for each group member.
- Loss history for each member of the group.  
(This must be obtained by you from the member's current insurer as they will not release this information to an outside party.)
- Complete a copy of Addendum I: Claims History for each claim
- Complete a copy of Addendum II: Prior Acts Coverage, for each member requesting this coverage.

*APA-endorsed Psychiatrists Professional Liability Insurance Program*  
*Administered By:* Professional Risk Management Services, Inc.  
1515 Wilson Boulevard, Suite 800  
Arlington, VA 22209  
(in California, d/b/a Cal-Psych Insurance Agency, Inc.)

Name of Agent: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

License #: \_\_\_\_\_