Please submit completed applications to submissions@cidinsurance.com or fax to (619) 593-2008.

CID Insurance Programs Inc. DBA CID Insurance Services

APPLICATION for:
Social Services Professional Liability Insurance (Claims Made)

1. Name of Applicant: _____

2. Physical Address: _____ Phone: ( ) _____

   City: _____ County: _____ State: _____ Zip: _____

   (If multiple names and locations, please attach list)

3. a) Date Established _____ Corporation ☐ Partnership ☐ Professional Assoc. ☐ Individual ☐

   b) In what states is the Applicant registered and licensed to practice? _____

   _____

4. Is the firm engaged in, owned by, associated with or controlled by any other business? ☐ Yes ☐ No

   If Yes, give details: _____

   _____

   _____

5. Professional Activities and Specialty (Attach narrative description if necessary). Check One:

   ☐ Alcohol/Drug Rehabilitation
   ☐ Day Care
   ☐ Day School (Mental Health/Retardation)
   ☐ Family Planning/Crisis Pregnancy
   ☐ Foster Care/Adoption Agency
   ☐ Group Home
   ☐ Hotlines (Phone Crisis Center)
   ☐ Meals on Wheels
   ☐ Mental Health Facility
   ☐ Mental Health
   ☐ Methadone Treatment
   ☐ Physical/Developmental Disability Facility
   ☐ Psychiatry
   ☐ Respite Care
   ☐ Shelter
   ☐ Sheltered Workshop
   ☐ Social Services
   ☐ Transitional Living
   ☐ Other (Specify): _____

6. State approximate division of Applicant's clients among:

   a) Alcoholics (%)
   b) Counseling/Family Planning (%)
   c) Drug Addicts (%)
   d) Mentally Retarded (%)
   e) Minors under age 18 (%)
   f) Psychiatric (%)
   g) Senile or Aged (%)

7. a. List the number and type of Applicant's employees and volunteers: If None, state None. _____

	Number	Type of Profession			
i)	____	Analyst	vi)	____	Psychiatrist
ii)	____	Counselor/Therapist	vii)	____	Physiotherapist
iii)	____	Psychoanalyst	viii)	____	Social Worker
iv)	____	Psychologist	ix)	____	Other: _____
v)	____	Psychotherapist			

b. Does the psychiatrist(s) above maintain their own insurance? ☐ Yes ☐ No
If Yes, for what limits? _____

c. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use separate sheet, if necessary.

_____

_____

_____

If None, state None. _____

d. Are all of the individuals listed in question 7.a. and 7.b. licensed in accordance with applicable state and federal regulations? If No, attach explanation. ☐ Yes ☐ No

(Attach detailed explanation for any "Yes" answers to the following:)

e. Has the Applicant or any of the individuals listed in question 7.a. and 7.b.:

i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

iii) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ☐ Yes ☐ No

8. Please provide the following information:

a. Number of Licensed Beds: _____

b. Number of Occupied Beds: _____

c. Number of Occupied Beds for Detox: _____

d. How many meals are served/delivered annually? _____

e. For Sheltered Workshop/Day School or Adult Day Care:
Number of participants: _____

f. For Adoption Agency/Foster Care:
Number of placements: _____

Number of placements with parents: _____

g. For Hotline/Phone Crisis Center:
Number of calls annually: _____

(Attach detailed explanation for any "Yes" answers to the following:)

9. Does the Applicant provide any medical treatment? ☐ Yes ☐ No
If Yes, please provide details.

10. State sources and amounts of total revenue:

Source	Amount Last Policy Year Est.	Amount This Policy Year
A. Charitable Contributions	$ _____	$ _____
B. Government Funding	$ _____	$ _____
C. Fee for Services	$ _____	$ _____
D. Other: _____	$ _____	$ _____
E. Other: _____	$ _____	$ _____
TOTAL GROSS REVENUE	$ _____	$ _____

11. Number of estimated client/patient encounters last 12 months:_____
(Note: "client/patient encounters" refers to number of visits – not number of client/patients)

12. Number of estimated client/patient encounters and client/patient services or tests in the next 12 months:

Client/Patient encounters: _____

13. Describe Professional Liability coverage for the last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If the expiring policy is claims made, what is the retroactive date? _____

14. Has any insurer cancelled or refused to renew any similar insurance during the past five years? ☐ Yes ☐ No

If Yes, please describe: _____

_____

15. Is the Applicant currently insured under a Commercial General Liability Policy? ☐ Yes ☐ No
If Yes, please give details:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If the expiring policy is claims made, what is the retroactive date? _____

16. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused? ☐ Yes ☐ No

If Yes, please give details: _____

_____

17. Has any claim ever been made against the firm or any of its employees? ☐ Yes ☐ No

If Yes, please submit currently valued carrier loss runs for the past 5 years and attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

18. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers? ☐ Yes ☐ No

If Yes, please give full details on the same basis as item 17.

19. Limits of Liability requested _____ Deductible _____

20. Desired term of policy: From _____ To _____

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein proper to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

For Kentucky residents:
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.

Name of Applicant: _____
Please Print Title

Signature: _____ SIGN HERE _____
Name Date

Please submit completed applications to submissions@cidinsurance.com
Attn: Sienna Vasquez
Any questions, please call (800) 922-7283
or fax to (619) 593-2008