

HUMAN SERVICES PROFESSIONAL LIABILITY RENEWAL APPLICATION



CAPITOL INDEMNITY CORPORATION | A Stock Company
 P. O. Box 5900 | Madison, WI 53705-0900 | CapSpecialty.com

HUMAN SERVICES PROFESSIONAL LIABILITY RENEWAL APPLICATION

Renewal of Policy Number: _____

THIS IS AN APPLICATION FOR THE RENEWAL OF THE INSURED'S PROFESSIONAL LIABILITY POLICY WITH THE INSURER SHOWN ABOVE.

INSTRUCTIONS:

- Answer ALL questions completely, leaving no blanks. If any questions, or any part thereof, do not apply, print "N/A" in the appropriate space.
- This Renewal Application must be completed and signed by an authorized partner, officer or other principal of the Named Insured shown in Question 1.1.

SUPPORTING DOCUMENTATION REQUIRED

Along with this completed and signed Renewal Application, the Insured must also submit the following:

- Financial Statement(s) for last fiscal year.

I. GENERAL INFORMATION

1.1	First Named Insured:		
	DBA:		Website:
	Business Address:		Phone Number:
	City, State, Zip:		
	County:		
1.2	Risk Management Contact Name*:		Title:
	*Please note that this person may be contacted about Risk Management Services offered by or through the Insurer.		
	Email Address:		Phone Number:

II. CLIENTS/OPERATIONS/SERVICES

2.1	What was the total number of clients served by the Insured this past year?	
2.2	In the past year, have there been any changes to the type of clients the Insured provides services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please explain:	
2.3	In the past year:	
	a. Have there been any changes to the type of services the Insured provides?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has the Insured begun providing any new services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Has the Insured discontinued any services previously provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes to any of the above, please explain:	
2.4	In the past year:	
	a. Have there been any changes to the Insured's business operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has the Insured begun any new business operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Has the Insured discontinued any of its business operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes to any of the above, please explain:	

III. REVENUE INFORMATION

3.1	Fiscal Year End Date:	Revenue – Past 12 Months: \$	Payroll – Past 12 Months: \$
3.2	Does the Insured currently sell any goods, products or services to third parties? (If yes, please fill in details below)		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Goods/Products:	Annual Receipts: \$	Description:
	Services:	Annual Receipts: \$	Description:

IV. SAFETY PRACTICES

4.1	Have there been any changes in the past year to the Insured's security systems or safety procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please explain:	

HUMAN SERVICES PROFESSIONAL LIABILITY RENEWAL APPLICATION

V. PROFESSIONAL STAFF

5.1 Please complete the schedule below for all Physicians and Psychiatrists currently contracted or employed by Insured. If necessary, provide information in a separate attachment:

	Physician #1	Physician #2	Physician #3	Physician #4
Name of Physician:				
Specialty:				
Employed or Contracted:	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted
DEA License:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of Years in Practice:				
Average number of hours working per week for Insured:				
Board Certified:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does Physician carry his/her own medical malpractice insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does it provide coverage for his/her conduct while providing services for or on behalf of Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any claims, suits, proceedings, or investigations related to this Physician been brought in the past five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

5.2 Please complete the schedule below indicating the current number of all staff. Do not include the staff already listed in question 5.1 above.

Position	Number of Employees		Number of Contractors		Number of Volunteers		Number of Interns	
	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time
Case Manager/Counselor:								
Child Care Worker:								
Chiropractor:								
Clergy:								
Clerical/Office Staff:								
CNA:								
Dental Assistant:								
Dental Hygienist:								
Dentist:								
Direct Support Professional:								
Medical Director (Admin Only):								
Medical Technician:								
Nurse Practitioner:								
Nurse - RN, LPN:								

HUMAN SERVICES PROFESSIONAL LIABILITY RENEWAL APPLICATION

Nutritionist/Dietician:									
Optometrist:									
Pharmacist:									
Pharmacy Assistant/Tech:									
Physician:									
Physician Assistant:									
Psychiatrist:									
Psychologist:									
Residential Manager:									
Social Worker:									
Teacher:									
Therapist - Occupational:									
Therapist - Physical:									
Therapist - Recreational:									
Therapist - Respiratory:									
Therapist - Speech:									
Other, specify:									
Other, specify:									

5.3 In the past year, have any of Insured's current or former employees been the subject of a child abuse/neglect investigation? Yes No
If yes, what were the results of the investigation?

VI. RESIDENTIAL FACILITIES N/A

- 6.1** In the past year, has the Insured opened any new residential facilities, or closed any residential facilities? Yes No
If yes, please explain:
- 6.2** In the next year, does the Insured plan to expand its residential facilities or increase the number of beds? Yes No
If yes, please explain:
- 6.3** Does Insured, at each facility, currently meet the state requirements for staff/client ratio at all times? Yes No

VII. IN-HOME CARE (SERVICES PROVIDED IN CLIENT'S HOME) N/A

7.1 Please provide Insured's current annual payroll for staff (employees and independent contractors) providing in-home services: \$

VIII. ADOPTION SERVICES AND FOSTER CARE N/A

- 8.1** Have there been any changes to the Insured organization's accreditations or certifications by the Council on Accreditation (COA), the applicable State Department of Human Services/Social Services, or other applicable organization? Yes No
- 8.2** Services currently performed by Insured: Adoption Services Foster Care Services
- 8.3** In the past year, have any of Insured's licenses to provide adoption services been suspended, revoked, or placed under conditional status by any state agency or other regulatory body? Yes No
If yes, please explain:
- 8.4** In the past year, have any complaints been made against Insured organization, or any current or past staff members, regarding adoption services? Yes No
If yes, please explain:
- 8.5** In the past year, has any child placed by Insured been seriously injured or died after placement? Yes No
If yes, please describe the circumstances:
- 8.6** Annual number of Adoptions Completed by Insured for the past year, and estimated total for the next year:
- | | | | | |
|-------------------|---------------------|--------------------------|----------------------|-------------------|
| Past Year: | Domestic Adoptions: | International Adoptions: | Embryonic Adoptions: | Failed Adoptions: |
| Next Year: | Domestic Adoptions: | International Adoptions: | Embryonic Adoptions: | Failed Adoptions: |
- 8.7** Failed Adoptions:
- Explain the reason(s) for the failed adoptions this past year:
 - What services were offered to adoptive parents and children to help avoid failure(s):
 - What happened to the children involved in the failed adoptions?
- 8.8** Does the Insured review other alternatives to adoption with the birth parent(s)? Yes No
- 8.9** Medical Information:
- Are children given a thorough medical examination, with prior conditions noted, before they are placed with the adoptive parents? Yes No
 - If placement is of a newborn child, are hospital records given to the adoptive parents at time of placement? Yes No
 - Are children given to adoptive parents upon release from hospital? Yes No
 - Does Insured perform genetic testing on children up for adoption? Yes No
 - Does Insured contract with a third party to perform genetic testing on children up for adoption? Yes No
- 8.10** Number of foster care placements made by/through Insured: Past Year - Actual:
Next Year - Projected:

HUMAN SERVICES PROFESSIONAL LIABILITY RENEWAL APPLICATION

8.11	What was the total stipend amount paid to all foster care parents (for placements made by/through Insured) this past year? \$
8.12	What was the number of hours of training received by foster parents, on average, this past year: Prior to placement: After Placement:
8.13	What is Insured's average number of foster care caseworkers, per manager?
8.14	What is the turnover rate, annually, of Insured's caseworkers for foster care? %
8.15	Does Insured contract with any municipality or municipal agency to provide foster care services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain and attach a copy of the contract(s).
8.16	On average, how many foster families does Insured use at any given time?
8.17	What is the maximum number of foster children allowed per foster home by Insured?
8.18	What is the number of total children (foster, adopted, natural) allowed per foster home?
8.19	What percentage of children placed by Insured annually are moved at least one time, from one foster home to another? %
8.20	What is the percentage of children placed by Insured annually, that have physical, developmental or mental disabilities? %
8.21	What is the percentage of children placed by Insured annually, that are medically fragile? %
8.22	Does Insured place children with the following disabilities? <input type="checkbox"/> Severely Autistic <input type="checkbox"/> Profound Mental Retardation <input type="checkbox"/> Bedridden Due to Physical Disability
8.23	How often are foster home inspections performed once a placement is made?
8.24	Who performs such home inspections?
8.25	What percentage of all home inspections are: Scheduled: % Unscheduled: %
8.26	Does each home inspection include a separate consultation alone with the child? <input type="checkbox"/> Yes <input type="checkbox"/> No
8.27	Which services is the Insured legally/contractually responsible for? (Check all that apply) <input type="checkbox"/> Placement of children in homes <input type="checkbox"/> Licensing of foster parents and homes <input type="checkbox"/> Supervision and inspection of homes If Insured contracts with a third party to provide any of the above services, please indicate which services and provide detail:
8.28	What steps are taken by Insured in the event of an alleged physical or sexual abuse of a child placed in foster care?

IX. CLAIMS AND INCIDENTS

Please respond to the following questions to the best of your knowledge and belief, after conducting due diligence and inquiry with any individuals who may have knowledge or information about the matters described below.

9.1	During the past year, has any Insured received notice of any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any proposed insured, relating to the policy referenced at the top of this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.2	During the past year, has any Insured, or any agent on its behalf, given notice to any prior professional or general liability insurance carrier of: a. Any claim, suit, legal proceeding, or regulatory proceeding or investigation, or licensure action or investigation against or involving any proposed insured? b. Any facts, circumstances or situations, which might give rise to a claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any proposed insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
9.3	Is any Insured aware of any facts, circumstances, situations, transactions, events, acts, errors or omissions which could reasonably be expected to give rise to a claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any insured, relating to the e policy referenced at the top of this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.4	During the past year, has any insured had a professional license or certification suspended or revoked, or been investigated by any licensing or certification professional organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No

The policy referenced at the top of this application, if renewed, **will not insure**: any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation disclosed, or which should have been disclosed, in response to the above; or any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation that arises from any fact, circumstance, situation, transaction, event, act, error or omission disclosed, or which should have been disclosed, in response to the above.

XI. REPRESENTATIONS AND SIGNATURE

By signing this Renewal Application, the undersigned represents and agrees, on behalf of the Named Insured and all insureds, to the following

- a. After conducting due diligence, the statements and answers furnished to the Company in this Application are accurate and complete to the best of his or her knowledge;
- b. Those statements and answers furnished to the Company are representations the Named Insured makes on behalf of all insureds;
- c. Those representations are a material inducement to the Company to provide a Quotation for a renewal policy;
- d. If a renewal policy is issued, the Company will have issued that renewal policy in reliance upon those representations;
- e. If there is any material change in the Named Insured's condition, activities or services, or in the statements or answers provided in this Renewal Application, that occurs or is discovered between the date this Renewal Application is signed and the effective date of any renewal policy, if issued, the Named Insured agrees to immediately notify the Company in writing; and
- f. The Company reserves the right, upon receipt of such notice, to modify or withdraw any Quotation previously offered by the Company.

As used above, the term "Company" refers to Capitol Indemnity Corporation.

NOTHING IN THIS RENEWAL APPLICATION SHOULD BE INTERPRETED TO MEAN THAT A RENEWAL POLICY WILL BE ISSUED TO THE NAMED INSURED, OR THAT ANY PERSONS, EVENTS OR OTHER SPECIFICS REFERENCED IN QUESTIONS, OR ANSWERS TO QUESTIONS, WILL BE COVERED UNDER ANY RENEWAL POLICY ISSUED TO THE NAMED INSURED.

X. 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

This Renewal Application must be signed by an authorized partner, officer or other principal of the Named Insured shown in Question 1.1 of this Renewal Application.

Signature of Authorized Representative of Named Insured

Title

Type / Print Name

Date

E-mail Address of Authorized Representative

This Section must be completed and signed by a Licensed Insurance Agent in the States of Iowa, Florida and any other states which require such signature.

Licensed Insurance Agent Signature

Agency Name / Agency Code

Type / Print Name

Insurance Agent License Number