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□ Capitol Indemnity Corporation
A Stock Company
P. O. Box 5900
Madison, WI 53705-0900

Human Services Professional Liability Renewal Application

INSTRUCTIONS

- The requested information is necessary before a quotation can be obtained.
- Type or print clearly.
- Answer ALL pertinent questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Underwriters will rely on all statements made in this application.
- This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on statements made in this application.
- The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

SUPPORTING INFORMATION

- Along with this completed and signed application, the applicant must also submit the information which is described below.
- Updated Five (5) years of loss information—for losses exceeding $50,000 and/or loss of life, physical or sexual abuse or professional liability then also attach a detailed description of loss/incident and describe corrective measures/lesson learned.
- Updated statements of Value (for property schedules)
- If autos or property coverage is written; updated Acord applications should be submitted.

A. GENERAL APPLICANT INFORMATION

First Named Insured _____ For Profit ☐ Not For Profit ☐

DBA _____ Website _____

Address _____ Phone Number _____

City, State, Zip _____ County _____

Contact Name _____ Title _____

Email Address _____ Phone Number _____

B. REVENUE INFORMATION

1. Fiscal Year End Date _____ Annual Operating Budget _____ Annual Payroll _____
2. Do you sell any goods or services to others? (If yes, please fill in details below) Yes ☐ No ☐

   Products: Annual Receipts _____ Description _____

   Services: Annual Receipts _____ Description _____

C. CHANGES TO SERVICES

1. Have there been any discontinued operations or services or will there be any new operations or services provided for the next year?

   Yes ☐ No ☐

   a If yes, please describe: _____

D. STAFF

1. Please complete the schedule below for Physicians and Psychiatrists (If necessary, please complete on an additional page)

	Physician #1	Physician #2	Physician #3	Physician #4
Name of Physician:				
Specialty:				
Employed / Contracted:				
DEA License:				
Years in Practice:				
Hours worked per week for you:				
Board Certified or Eligible:				
Does Dr. carry their own malpractice insurance?				
If yes, does it include acts while working for your operation?				
Any claims related to this Dr. in the past 5 years?				

2. Please complete the schedule below indicating the *number* of all Staff that are not listed in above ☐ See Attached Staff List

POSITION	# of EMPLOYEES		# of CONTRACTORS		# of VOLUNTEERS		# of INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Case Manager:								
Child Care Worker:								
Chiropractor:								
Clerical/Office Staff:								
CNA:								
Counselor:								
Dental Assistant:								
Dental Hygienist:								
Dentist:								
Home Health Aid:								
M.D./D.O.:								
Medical Director (Admin Only):								
Medical Technician:								
Nurse Practitioner:								
Nurse—LPN:								
Nurse—RN:								
Nutritionist/Dietician:								
Optometrist:								
Pharmacist:								
Pharmacy Assistant/Tech:								
Physician Assistant:								
Psychiatrist:								
Psychologist:								
Residential Care Worker:								
Residential Manager:								
Social Worker-Bachelors (BSW)								
Social Worker-Bachelors (MSW)								
Teacher:								
Therapist - Occupational:								
Therapist - Physical:								
Therapist - Recreational:								
Therapist - Respiratory:								
Therapist—Speech:								
Other (specify):								
Other (specify):								

FRAUD WARNINGS

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 and subjects that person to criminal and civil penalties. (Not applicable in AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, WA and WV).

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

APPLICABLE IN CO
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.

APPLICABLE IN FL AND OK
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 (of the third degree)*. *Applies in FL only.

Applicable in KS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN KY, NY, OH, AND PA
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

APPLICABLE IN ME, TN, VA AND WA
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 and denial of insurance benefits. *Applies in ME only.

APPLICABLE IN NJ
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN OR
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

REPRESENTATIONS

This Application must be signed by an authorized partner, officer or other principal of Applicant of this Application. By signing this Application, Applicant represents the following:

The statements in the Application or Renewal Application furnished to the Company are accurate and complete;

Those statements furnished to the Company are representations Applicant makes on behalf of all proposed Insureds;

Those representations are a material inducement to the Company to provide a premium proposal;

If a policy is issued, the Company will have issued this Policy in reliance upon those representations;
If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report to the Company in writing; and

The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company.

As used herein, the "Company" shall be Capitol Indemnity Corporation.

NOTHING IN THIS APPLICATION SHOULD BE INTERPRETED TO MEAN THAT COVERAGE WILL BE OFFERED OR THAT ANY ITEMS REFERENCED IN QUESTIONS OR ANSWERS TO QUESTIONS WILL BE COVERED EVEN IF COVERAGE IS OFFERED AND BOUND. SOME RESPONSES MAY REQUIRE MORE SPACE THAN THAT PROVIDED IN THE APPLICATION ITSELF. PLEASE PROVIDE THOSE RESPONSES ON A SEPARATE PAGE AND ATTACH IT TO THIS APPLICATION. THE APPLICANT AGREES IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, THAT THIS APPLICATION AND ANY ATTACHMENTS ARE DEEMED ATTACHED TO AND INCORPORATED INTO THE POLICY. BY TYPING MY NAME IN THE FIELD BELOW, I AGREE IT IS EQUIVALENT TO MY SIGNATURE ON THIS DOCUMENT AND I CONSENT TO CONDUCT THE TRANSACTION TO WHICH THIS DOCUMENT IS APPLICABLE BY ELECTRONIC MEANS.

Signature of authorized representative of Applicant	**Title**
Type / Print name of authorized representative	**Date**
E-mail address of authorized representative	