GREAT AMERICAN INSURANCE GROUP | Specialty Human Services Surplus Line

Professional Liability Questionnaire

Please attach an Acord® Application

Organization Information

Name of organization _____

Website address (URL) _____

Date Business Operations Started _____

Inspection Contact _____

Contact phone number _____ Contact email _____

Current form of insurance:

Professional Liability	☐ Occurrence	☐ Claims Made
Commercial General Liability	☐ Occurrence	☐ Claims Made

Applicant is a:

☐ Corporation ☐ Joint Venture ☐ Sole Proprietorship ☐ Professional Association

☐ Partnership ☐ Other (please explain) _____

Applicant Operates

☐ For Profit ☐ Not For Profit

		Yes	No
1.	Is your organization required to be licensed in your state?	☐	☐

2. List all accreditations or licenses _____

3. Indicate the number of clients in each age range:
1-4 years _____ 5-12 years _____ 13-18 years _____ 19-60 years _____ 60-75 years _____ 76+ years _____

Services		Number of
Home Healthcare Agency	☐	Home Health Visits Annually _____
Medical/Testing Laboratory	☐	Tests Annually _____
Nurses Registry	☐	Average Length of Placement _____
Outpatient Medical Clinic	☐	Outpatient Visits Annually _____
Outpatient Mental Health Clinic	☐	Outpatient Visits Annually _____
Residential Healthcare Facility	☐	Beds _____
Residential Mental Health Facility	☐	Beds _____
Referral Agency	☐	Calls Annually _____
Emergency Call Center/Crisis Hotline	☐	Calls Annually _____

State approximate % of gross income derived from the following (total should be 100%):

_____%	Alcohol Abuse Counseling	_____ %	DUI Classes
_____%	Drug Abuse Counseling	_____ %	Inpatient Detox
_____%	Mental Health Counseling/Evaluations	_____ %	Mental Health Group Home
_____%	Family Counseling	_____ %	Hospice
_____%	Physical/Occupational/Speech Therapy	_____ %	Halfway House
_____%	Blood/Urine Testing (Drug/Alcohol)	_____ %	Supervised Living
_____%	Referrals	_____ %	Adoption/Foster Care
_____%	Methadone Maintenance	_____ %	Recreation Programs
_____%	Diagnostic Testing	_____ %	Training
_____%	Pre-Employment Testing		
_____%	Other _____		

Applicant Operates *Continued*

4. Total annual gross revenue/operating budget $ _____

5. Total payroll of employees $_____

	Yes	No
6. Has any client in your care ever attempted or committed suicide?	☐	☐
If yes, how many instances have occurred over the past year _____		
7. Are your clients ever physically restrained to control behavior?	☐	☐
If yes, how many instances have occurred over the past three year _____		

8. Indicate the number of professionals working for your organization, if any. **If insurance is needed for these professionals complete separate "Individual Medical Professional" questionnaire.**

Name of Position	Number of Employees	Number of Contractors	Est Hrs Worked Employees
Medical Doctor, Psychiatrist			
Nurse Practitioner, Physician Assistant			

9. Complete the required information for all employees (full or part-time), volunteers, and contractors by position below.

Name of Position	Number of Employees	Number of Contractors	Est Hrs Worked Employees	Est Hrs Worked Contractors	Est Annual Payroll Employees	Est Annual Payroll Contractors
Administrator						
Child Care Worker						
Community Support Specialist						
Counselor						
Dentist/Dental Hygienist						
Home Health Aide						
Medical Students						
Nurse Assistant						
Nurse Practitioner						
Nurse - LPN						
Nurse - RN						
Nutritionist/Dietician						
Optometrist						
Paramedic/EMT						
Pharmacist						
Physician Assistant						
Physician						
Psychiatrist						
Psychologist						
Resident Home Care Provider						
Resident Manager						
Social Worker – Bachelors (BSW)						
Social Worker - Masters (BSW)						
Teacher/ Tutor/ Aide						
Technician – Medical/ Lab						
Therapist - Occupational						

Applicant Operates *Continued*

Name of Position	Number of Employees	Number of Contractors	Est Hrs Worked Employees	Est Hrs Worked Contractors	Est Annual Payroll Employees	Est Annual Payroll Contractors
Therapist - Physical						
Therapist - Speech/ Hearing						
Therapist - Other						
Other Positions (Specify) _____						

	Yes	No
10. Of the employees, volunteers, and contractors listed above, do any carry their own professional liability insurance?	☐	☐
If yes, are procedures in place to verify current insurance is maintained at all times?	☐	☐
11. Do you maintain copies of licenses for all employed, volunteer and contracted professionals who are required to be licensed?	☐	☐
If yes, are procedures in place to verify current insurance is maintained at all times?	☐	☐
12. Has any organization employee ever been reprimanded, refused admission or suspended by any association or administrative agency?	☐	☐
13. Has your organization's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency?	☐	☐
14. Have there been any allegations of negligence or failure to comply with any regulatory or licensing guidelines within the past 5 years?	☐	☐
15. As respects professional liability coverage, is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy?	☐	☐
16. Does your organization provide referrals to other privately operated organizations (those that are not operated by governmental entities e.g. a city or county clinic)?	☐	☐

If yes, complete a - f:

a. Provide estimated annual number of referrals for:

_____ Adoption/Foster Placements
_____ Counseling
_____ Daycare/latchkey
_____ In-home assistance
_____ Medical care
_____ Group home placement or housing

Other – describe _____

b. Are service providers for your organization licensed by state?	☐	☐
c. Does your organization verify that service providers have insurance in place?	☐	☐
d. Does your organization have a written contract with service providers?	☐	☐
e. Are hold harmless agreements in your favor part of the contract between your organization and service providers?	☐	☐
f. Does your organization require service providers name you as additional insured under the provider's policy?	☐	☐

Claims History

	Yes	No
1. Are you aware of any circumstance which may result in a general liability (including Abuse and Molestation) or professional liability claim or suit being made against you?	☐	☐

2. Please list the general liability (including Abuse and Molestation) and/or professional liability carrier for each of the past five years. **If none,** state "**none**."

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Policy Period	Claims-Made?
						☐ Yes ☐ No Retro Date _____
						☐ Yes ☐ No Retro Date _____
						☐ Yes ☐ No Retro Date _____
						☐ Yes ☐ No Retro Date _____
						☐ Yes ☐ No Retro Date _____

Please attach a copy of the following with your submission:

- **Most recent state survey**
- **Current license**
- **Loss Runs**

WARRANTY, AUTHORIZED SIGNATURE AND CONTINUING DUTY TO UPDATE

The undersigned is an authorized representative of the prospective Named Insured, and acknowledges that the information provided with the Application, including all questionnaires, supplements, attachments, and replies to underwriter inquiries and applications form other insurance companies which have been submitted to Great American and made part of this application:

1. **Will be relied upon by Great American Insurance Group insurers in determining the acceptability of the prospective Named Insured and the premium amount to be charged;**
2. **Are true, accurate and complete; and**
3. **Will be considered an integral part of any resultant insurance contract.**

The undersigned further agrees that the prospective Named Insured has a continuing duty, through the date of policy inception, to update this Application, including all questionnaires, supplements, and replies to underwriter inquiries.

Signature and printed name and title of authorized representative of applicant and date signed:

Signed _____ **Name** _____

Title _____ **Date** _____