ROYAL OAK UNDERWRITERS, INC.
Excess and Surplus Lines Insurance Wholesalers

8417 Patterson Avenue
Richmond, Virginia 23229
Telephone: (804) 741-7999
WATTS: (800) 628-2967
Fax: (804) 741-9401
www.royaloakunderwriters.com

Social Services Professional Liability Insurance (Claims Made)

1. Name of Applicant: _____

2. Physical Address: Name _____ Phone: _____

Address _____

City _____ County: _____ State ____ Zip Code _____

(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 Speciality (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/Development Disability Facility
- ☐ Psychiatry
- ☐ Respite Care
- ☐ Shelter
- ☐ Sheltered Workshop
- ☐ Social Services
- ☐ Transitional Living
- ☐ Other _____

6. State approximate division of Applicant's clients among: (enter as a decimal)

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

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

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

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 on 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 fro 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 in 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 Care: Number of Participants: _____
f. For Adoption Agency/Foster Care: Number of Participants: _____
g. For Hotline/Phone Crisis Center: Number of call annually: _____

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9. Does the Applicant provide any medical treatment?

If "Yes", please provide details.

☐ Yes ☐ No

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: _____ Client/Patient Services: _____

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

Carrier	Limit	Deductible	Premium	Expiration|mm/dd/yyyy

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:

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15. Is the Applicant currently insured under a Commercial General Liability Policy? ☐ Yes ☐ No

Carrier	Limit	Deductible	Premium	Expiration Date|mm/dd/yyy

If 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 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: _____

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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: _____ Title: _____

Signature: _____ Date: _____

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