Western World
INSURANCE GROUP

Outpatient Counseling
General Liability & Professional Liability
Supplemental Application
(Complete in addition to ACORD)

1. Name of Applicant: _____
2. Website Address: _____
3. List full name of individual or partners and their interests: _____

_____

4. Please provide number of employed or contracted personnel:	Number Employed	Number Contracted	Number of Volunteers
Master Social Worker (MSW)			
Licensed Clinical Social Worker (LCSW)			
Licensed Mental Health Counselor			
Psychologist			
Psychiatrist			
Physician			
Other (Specify): _____			

5. List other professional training, licenses and certificates held by your staff: _____

_____

6. a. If a "For-Profit", previous 12 months gross sales: $ _____
   Anticipated gross sales for policy period: $ _____
   b. If a "Not-For-Profit", previous 12 months outpatient visits: _____
   Anticipated outpatient visits for policy period: _____
   Operating budget or funding: $ _____
   c. Anticipated number of "Hot Line" calls for policy period: _____
7. Do you offer any of the following?
   - ☐ Counseling in conjunction with obstacle courses
   - ☐ Counseling of persons convicted of violent crimes
   - ☐ Counseling of sex crimes offenders
   - ☐ Dispensing of medication
   - ☐ Regression therapy
   - ☐ Screening of foster parents
   - ☐ Smoking cessation programs
8. Does anyone on your staff prescribe any medication? ☐ Yes ☐ No
9. Do you dispense methadone? ☐ Yes ☐ No
   Is methadone allowed to be taken off your premises? ☐ Yes ☐ No
10. Please indicate percentage of counseling:

____% Abortion*	____% Adoption screening*	____% Alcohol & Drug
____% Anger Management	____% Child Development	____% Domestic Abuses*
____% Faith-Based	____% Grief Counseling	____% Hypnotherapy
____% Hot Line*	____% Interventions*	____% Legal*
____% Marriage & Family Therapy	____% Pregnancy Counseling	____% Primary Drug Detoxification
____% Prison Release/Probation	____% Psychological Evaluations	____% Social Work/Case Management
____% Victims of Violent Crimes	____% Other (specify): _____	

*If any, provide specifics: _____

_____

11. What mental disorders/diseases do you specialize in treating? _____

_____

12. What percent of your patients are under the age of 18? _____%

13. If you regularly treat children in your practice, have you had training in recognizing and treating children who may have been the victims of abuse? ☐ Yes ☐ No

14. Do you report all suspected cases of child abuse to the appropriate authorities? ☐ Yes ☐ No

15. Indicate percent of time spent in the following work locations:

____% Assisted Living facilities ____% Emergency Department of Hospitals

____% In-Patient Center/Clinic ____% Nursing homes ____% Outpatient clinic or office

____% Patient's homes ____% Prisons ____% Schools

____% Hospital ward (specify): _____

____% Other: _____

16. Check all procedures you use when hiring professional, paraprofessional, or any other employee who will provide patient care services at your facility:

a. Educational background or residency program check, when applicable. ☐ None ☐ Verbal ☐ Written

b. Previous employers check. ☐ None ☐ Verbal ☐ Written

c. Police background check. ☐ None ☐ Verbal ☐ Written

d. Drug screening. ☐ None ☐ Verbal ☐ Written

17. Are you licensed by the state in which you practice? ☐ Yes ☐ No

18. List any professional association of which you are a member: _____

_____

19. Have you participated in any continuing education programs in your field? ☐ Yes ☐ No

20. If only professional liability coverage is desired, name your general liability insurer, along with your policy number, policy limits, and the effective date: _____

_____

21. Do you want your policy to cover your employees for their liability? (There is a charge.) ☐ Yes ☐ No

NOTE: The policy already protects *you* for the acts of your employees.

22. Do all doctors carry their own Professional Liability Coverage? ☐ Yes ☐ No

If the insured is an individual (not a Corporation), please answer questions 23 through 26.

23. Are you an employee of another person or organization? ☐ Yes ☐ No

If yes, what is the name of your employer? _____

24. Do you have any management or supervisory responsibilities? ☐ Yes ☐ No

25. If you contract your services to others on an independent contractor basis, for whom do you work? _____

_____

26. Are you in private practice? ☐ Yes ☐ No

SEXUAL MOLESTATION COVERAGE: Sexual Molestation liability is offered for an additional premium charge.

If sexual molestation coverage is not desired, please check here ☐ Coverage is not requested.

27. Have you had any incidents or claims brought against you for sexual molestation or any other allegations of misconduct? ☐ Yes ☐ No

28. If you have employees, are there written guidelines in place regarding sexual misconduct? ☐ Yes ☐ No

If **NO**, please explain: _____

29. Please check the limits you are requesting: ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000

_____ _____

Applicant's Signature Date

_____ _____

Title Producing Agent