



REQUEST FOR QUOTE



Occurrence Form Group Entity/Corporate or Non-Profit Coverage

Note: This program is designed for outpatient mental health and allied health services. If you provide inpatient or residential programs, CONTACT US for the correct form. **THIS FORM IS FOR A NON-BINDABLE QUOTE FOR COVERAGE. IN ORDER FOR A POLICY TO BE ISSUED, A FULLY COMPLETED APPLICATION WILL BE REQUIRED.**

Applicant Information

1. Contact Information

Company Name:	Residence Phone:	
Attn/Address 2:	Business Phone:	
Street:	Fax:	
City, State, Zip:	Email:	
Contact Name:	Current Carrier:	Expiration Date:

Are you a member of a professional association? If so, please indicate: _____

a. Does your business have a website? If Yes, enter the URL address here: http://_____

b. If you do not have a website that describes the services you provide, please attach one or more of the following: (check items attached): Company brochure Business Plan Description of the scope of all services provided*

c.* Please include a written description of all services provided: _____

Professional Liability and Additional Optional Coverages

2. Choose coverage limits to be quoted:

- \$1 Million Each Occurrence/\$3 Million Aggregate
- \$1 Million Each Occurrence/\$5 Million Aggregate
- \$2 Million Each Occurrence/\$4 Million Aggregate (Oregon and Virginia Only)
- \$3 Million Each Occurrence/\$5 Million Aggregate (Virginia Only)

- General Liability (\$1,000,000 per incident/\$3,000,000 aggregate)
- Business Personal Property* (\$15,000 limit)
*Only available if also purchasing General Liability
*Property Coverage not available in Florida
- Sexual Abuse/Molestation (\$1,000,000 limit)
- Hired & Non-Owned Auto (\$1,000,000 limit)
- Business Income and Extra Expense (\$250,000 limit)

Schedule of Staff

3. Indicate the total number of owners, W-2 employees and volunteers under each license. **Independent Contractors should only be included in your totals if they require coverage under your policy and do not have their own policies.**

Occupation	# of Owners, Partners or Principals	# of Employees, contractors or Volunteers	Occupation	# of Owners, Partners or Principals	# of Employees, contractors or Volunteers
Counselor			Behavior Therapist		
PhD Psychologist			Case Manager		
MA Psychologist			Social Worker		
LMFT/MFT			RN/LPN/LVN		
BCBA/BCABA			Nurse Practitioner		
Dietician/Nutritionist			Post-Masters/Intern		
Speech Pathologist			Practicum Student		
Audiologist			Paraprofessional		
Occupational Therapist			Other (describe)		

Have you ever been involved in a claim? YES NO
If yes, please attach a Loss History and description of the incident.

Desired Policy Effective Date: ____/____/____

How would you like to receive your quote? Email Fax Mail