Outpatient Counseling

Occurrence Form

Group Entity/Corporate or Non-Profit Coverage Application

NOTE: This program is designed for outpatient mental health and allied health services. If you provide inpatient or residential programs, CONTACT US for a different application.

Applicant Information	*For office use only: Approved_________ Effective Date:________*	
1. **Contact Information**		
Company Name:	**Residence Phone**:	
Attn/Address 2:	**Business Phone:**	
Street:	**Fax:**	
City, State, Zip:	**Email**:	
Contact Name:	**Current Carrier:**	**Expiration Date:**

** How did you hear about us? ☐Professional Association ☐Internet Search ☐Advertisement in Publication ☐Facebook ☐Co-Worker/Friend/Colleague ☐Previously Insured by CPH ☐Other____________________

2. How would you like to receive your policy documents? ☐Email ☐Fax ☐Mail

3. 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 the scope of all services provided:**

   ____

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   ____

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4. Check Associations with which your membership is currently active:

☐ AMHCA & State Chapters ☐AAMFT ☐ATRA ☐ ACA ☐APBA ☐ASCA ☐CAMFT
☐CSWA ☐CSCSW ☐IAMFC ☐NANP ☐AANC ☐No Association/Association Not Listed

Professional Liability

5. **Choose ONE set of limits of liability for the group:**

☐ $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**)*

***All Other States**: If you have a contract requiring these limits, please submit the contract showing this requirement.

6. **Staff**

Please list the names and credentials of your staff. List W-2 employees in section B and 1099 employees in section C.

Do you require each of these names to be listed on a Certificate of Insurance? ☐ Yes ☐ No

B. Coverage for W-2 Employees and Volunteers ONLY (No Independent Contractors) **All W-2 Employees must be listed **

List the Names of the W-2 employees/volunteers to be insured under this policy	Occupation*: List License or Certification	Employment Status: Is this person and Owner/Partner, or Group Principal?	Is this person a W-2 Employee or Volunteer?
1.		☐ Yes ☐No	☐ W-2 ☐Volunteer
2.		☐ Yes ☐No	☐ W-2 ☐Volunteer
3.		☐ Yes ☐No	☐ W-2 ☐Volunteer
4.		☐ Yes ☐No	☐ W-2 ☐Volunteer
5.		☐ Yes ☐No	☐ W-2 ☐Volunteer
6.		☐ Yes ☐No	☐ W-2 ☐Volunteer
7.		☐ Yes ☐No	☐ W-2 ☐Volunteer
8.		☐ Yes ☐No	☐ W-2 ☐Volunteer
9.		☐ Yes ☐No	☐ W-2 ☐Volunteer
10.		☐ Yes ☐No	☐ W-2 ☐Volunteer
11.		☐ Yes ☐No	☐ W-2 ☐Volunteer
12.		☐ Yes ☐No	☐ W-2 ☐Volunteer
13.		☐ Yes ☐No	☐ W-2 ☐Volunteer
14.		☐ Yes ☐No	☐ W-2 ☐Volunteer
15.		☐ Yes ☐No	☐ W-2 ☐Volunteer

*** For any Paraprofessionals (unlicensed or uncertified), please indicate their job title.**

If you require more space, please use a separate sheet of paper using the same format as outlined above.

NOTE: We are **unable** to cover professionals prescribing medications. Please provide proof of professional liability coverage for any such professionals.

Do you have 1099 independent contractors working for your company that require coverage under this policy (i.e. they do not carry their own professional liability coverage?) ☐ **Yes** ☐**No** .

⟶ **If YES, please provide the names and credentials of each independent contractor in section C below:**

C. Coverage for Independent Contractors (Only list those contractors who need coverage under this policy)

List the names of the Independent Contractors to be insured under this policy	Occupation*: List License or Certification
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

*** For any Paraprofessionals (unlicensed or uncertified), please indicate their job title.**

If you require more space, please use a separate sheet of paper using the same format as outlined above.

NOTE: We are **unable** to cover professionals prescribing medications. Please provide proof of professional liability coverage for any such professionals.

7. a. Does your state require all licensed providers to complete Continuing Education in **Law or Ethics** for licensure renewal? ☐ Yes ☐No

b. If yes, are all licensed providers in compliance?.. ☐ Yes ☐No

Optional Supplemental Coverages

- Items #8-#18 are OPTIONAL coverages, and are not required to be added.
- These coverages will be subject to additional underwriting approval and premium.
- By signing this application, you are acknowledging that you have considered your necessity of these optional coverages, and have agreed to add or not add them.

8. **Additional Insureds**

This coverage extends protection to the additional insured entity under your policy.

I would like to add this coverage ……………..…….. ☐ Yes ☐No

Please complete the below information to add an additional insured on your policy*.

Landlords (added at no additional premium):

Landlord Name:

Attn:

Street:

City, State, Zip:

Premises Being Leased:

All Others (added at 10% of your professional liability premium each):

1.) Entity Name:	2.) Entity Name:
Attn:	Attn:
Street:	Street:
City, State, Zip:	City, State, Zip:
Nature of Professional Relationship:	Nature of Professional Relationship:

***If you require more space, please use a separate sheet of paper using the same format as outlined above.**

9. **State Licensing Board Increase**

Your policy includes **$35,000** for defense of a **State Licensing Board Investigation**. You have the option to **increase this coverage.**

I would like to increase this coverage ……………..…….. ☐ Yes ☐No

Select your increase: ☐ Increase this limit to $75,000 ($75.00 additional premium)

☐ Increase this limit to $100,000 ($100.00 additional premium)

10. **CPH TOP Coverage**

The CPH TOP® Provides General Liability "Slip and Fall Coverage" and Personal Property Coverage Protection.

General Liability Coverage includes **$1 Million/$3 Million limits** for Bodily Injury and Property Damage Liability.

Personal Property Coverage provides **up to $15,000** for property that is in your care, custody, or control.

*Property coverage is NOT available in Florida

I would like to add CPH TOP or Only General Liability coverage ……………..…….. ☐ Yes ☐No

Select Which Option: ☐ CPH TOP (General Liability AND Property Coverage): **$332** *Not available in Florida

☐ General Liability ONLY: **$182**

To add CPH TOP® or General Liability coverage, provide full street addresses for each location to be covered.

Please use a separate sheet of paper for more than 2 locations.

Location 1	Location 2
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Have you had any General Liability losses within the last 3 years?... ☐Yes** ☐No

**If yes, please provide an explanation:

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Optional Supplemental Coverages (Continued)

11**. Sexual Abuse/Molestation (Rating basis for limits of $1,000,000 each occurrence/ $1,000,000 aggregate)**

I would like to add this coverage …………..…….. ☐ Yes ☐No

Do you provide background checks for all employees? ……… ☐ Yes ☐No

Additional Premium: $300 (First Person) + $50 (Each Additional Employee)

12**. Non-Owned/Hired Auto Liability (Rating basis for limits of $1,000,000 each occurrence/$1,000,000 aggregate)**

Protects your business for liability resulting from an employee's use of their own vehicle for a business purpose. There is no protection for collision or physical damage to personnel's vehicles.

I would like to add this coverage …………..…….. ☐ Yes ☐No

Do you provide transportation to clients? ……… … ☐ Yes ☐No If **yes**, what percentage of auto services?______%

Do you check Motor Vehicle Records of all employees using their vehicles for work purposes**? ………** ☐ Yes ☐No

Do you verify that each employee maintains at least the minimum state requirement for personal auto insurance coverage? …☐ Yes ☐No

Additional Premium: $80 (1-10 employees) + $8 (Each Additional Employee)

**This coverage is only applicable for those companies who have employees. **

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13. **Business Income and Extra Expense (Rating basis for limits of $250,000)**

You must also add CPH TOP to be eligible for this coverage.

I would like to add this coverage …………..…….. ☐ Yes ☐No

Additional Premium: $50

14**. Separate Limits**

When you take out a corporate/group policy, the corporate/group name is automatically covered under a single set of limits that is also shared by the insured individuals listed on the policy. We offer the option to purchase "Separate Limits", which adds an identical set of limits for the corporate/group name in additional to the limits shared by the insured individuals. This can be added at an additional charge of **10% of your professional liability premium**.

I would like to add this coverage …………..…….. ☐ Yes ☐No

15**. Additional Insured Corporation**

This endorsement will extend coverage to an additional corporation that you own that provides similar services, and employs the same staff**.** This can be added at an additional charge of **10% of your professional liability premium**.

I would like to add this coverage …………..…….. ☐ Yes ☐No

Name of Additional Entity(s): ______________________________________

Website or Description of Services:____

Are all staff for this corporation included on question #6?……… ☐ Yes ☐No

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16**. Work Outside Endorsement**

This coverage can be provided to the owner(s) of the corporate/group entity who also provide services outside of this entity. This can be added at **no additional charge**.

I would like to add this coverage …………..…….. ☐ Yes ☐No

Name(s) of applicable owner(s): ______________________________________

17**. Additional Occupation**

Do you or any of your employees provide services as a Coach, Hypnotherapist, Biofeedback, Mediator, etc? Coverage can be extended to services provided under this licensure/certification for an additional charge of **10% of your professional liability premium.**

I would like to add this coverage …………..…….. ☐ Yes ☐No

Services/License to be covered: ______________________________________

Qualification Questions

18. Have you or any of your employees ever been refused coverage for professional liability or malpractice insurance or has your malpractice or professional liability insurance ever been canceled or declined for renewal (non-renewed)? ☐Yes ☐No

19. Has any claim or suit ever been brought against you or any of your employees for alleged malpractice or professional liability, or are you aware of any incident or existing circumstances that might reasonably lead to a claim or suit? ☐Yes ☐No

20. Have you or any of your employees ever been convicted of a misdemeanor or felony? ☐Yes ☐No

21. Have you or any of your employees ever had your license, certification or registration suspended, revoked, or placed on probation by a licensing board, board of examiners, or any other governmental entity that regulates your profession? ☐Yes ☐No

22. Have you or any of your employees received a citation or paid a fine as a result of a board proceeding? ☐Yes ☐No

23. Have you or any of your employees surrendered, either voluntarily or otherwise, your license, certification, or registration? ☐Yes ☐No

24. Have you or any of your employees ever been accused of sexual misconduct or any professional impropriety? ☐Yes ☐No

25. Have any complaints ever been filed against you or any of your employees or have there ever been any formal or informal investigations or inquiries opened with a peer review committee or an ethics committee of a professional association, hospital, health care facility, or any other governmental or private entity? ☐Yes ☐No

26. Do you know of any reason why you or any of your employees cannot comply with the legal, ethical, or professional standards set by law, by regulation, by a peer review committee or by an applicable code of ethics in any jurisdiction where you provide services? ☐Yes ☐No

If your answer to any of the above questions is "yes", please provide a detailed explanation below. Please also provide any pertaining documentation (i.e. Dismissal Letters, Consent Agreements, etc…)

***Please include a written description of the "Yes" answer above:**

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Confirm: Please Read, Sign & Date Below

The applicant declares the information contained in the application is true and that no material facts have been suppressed or misstated. The applicant understands that incorrect information could void the Insurance coverage. The signing of this application does not bind the undersigned to purchase this insurance, nor does the review of the application bind the insurance company to issue a policy. It is agreed that this application shall be the basis of the contract should a policy be issued. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act.

Signature of Group Principal:____________________________ **Today's Date**:________________ **Desired Effective Date:**________________

Thank you for choosing CPH & Associates!

If your application is approved, you will receive a quote within 48 hours with payment instructions.

Office Hours:

Monday - Friday 8:30 AM-5 PM CST

711 S. Dearborn, Suite 205, Chicago, IL 60605 Fax: 312-987-0902 Phone: 800-875-1911

***E-mail**: applications@cphins.com **Website**: www.cphins.com*