Preferra Insurance Company RRG

GROUP RENEWAL APPLICATION FOR NASW SOCIAL WORKERS

If you have questions, please call the Preferra RRG Plan Administrator: **888.278.0038**
Renew online at SocialWorkInsure.com

NOTICE: THIS IS A CLAIMS-MADE FORM: EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED HEREIN, THE COVERAGE OF THIS POLICY IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE COMPANY WHILE THE POLICY IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE THE SPECIAL PROVISION "SEXUAL MISCONDUCT" IN THE POLICY).

1. APPLICANT INFORMATION

Company Name _____ Owner/Principal _____ Business Phone _____

Street Address _____

City _____ State _____ Zip _____ Email _____

Policy Number _____ Expiration Date _____

Does your business have a website? ◯ YES ◯ NO If YES, enter the URL address here: http:// _____

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

2. PROFESSIONAL LIABILITY

Choose ONE set of limits of liability for the group:

◯ **Option 1:** $1,000,000 per occurrence/$3,000,000 aggregate
◯ **Option 2:** $1,000,000 per occurrence/$5,000,000 aggregate
◯ **Option 3:** $2,000,000 per occurrence/$4,000,000 aggregate
◯ **Option 4:** $3,000,000 per occurrence/$5,000,000 aggregate*

**This additional option is available for VA residents only.*

3. SCHEDULE OF EMPLOYEES

You MUST list the number of all W2 employees. **At least one person must be designated as owner, partner, or principal.**

Indicate the NUMBER of individuals per occupation. Do not list the names of individuals. Do not list independent contractors.
Designate only ONE occupation per person, at their highest credential. ***You will be charged twice if you designate the same person in two different boxes.***

OCCUPATION	# OF OWNERS, PARTNERS, OR PRINCIPALS	# OF EMPLOYEES	OCCUPATION	# OF OWNERS, PARTNERS, OR PRINCIPALS	# OF EMPLOYEES
Administrative			LEP/ Master's Psychologist		
Counselor			Social Worker		
Psychologist (Doctoral Level)			Marriage & Family Therapist		
Paraprofessional			Student		
Other			Other		

a. Total Number of Owners/Partners/Principals: _____ **b. Total Number of Employees:** _____

All employees listed must meet State continuing education requirements in order to be eligible for coverage.

b. Do you have Business Owners to name on your Certification of Insurance? ***Owner(s)***:_____

Separate Owners with a comma

4. INDEPENDENT CONTRACTORS

Do you use any 1099 Independent Contractors whose services are in the mental health field? ◯ YES ◯ NO If YES, how many? _____ *The cost is $25 per Independent Contractor.*
You will be covered for their acts, subject to the terms and conditions of the policy, but the independent contractor will not be individually insured under this policy.

5. STATE LICENSING BOARD INCREASE (OPTIONAL)

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

◯ Increase my limit to $50,000–*$50 additional premium* ◯ Increase my limit to $75,000–*$75 additional premium* ◯ Increase my limit to $100,000–*$100 additional premium*

6. ADDITIONAL INSUREDS (OPTIONAL)

Add the following to your professional liability premium (from Section 3):

◯ Add **Landlord** (please provide a written lease naming them as Lessor, Limited to 1 Lessor per office location*)–*No Charge*

◯ Add **All Others** (please indicate the nature of your professional relationship–e.g. agencies, employers, supervisors, property managers, etc.)–*$25 additional premium for each*

To add additional insureds, please provide their information on page 3.

Limited to 1 Lessor per office location,* ***each additional landlord is $25*

7. QUALIFICATION QUESTIONS

Answer for all employees:

1. Have you ever been the subject of a reprimand or disciplinary action, refused employment or admission to a professional society, had your professional privileges suspended by any court or administrative agency, or been the subject of any ethics investigation at a local, state, or national level? ◯ YES ◯ NO
2. Has any insurance ever been cancelled or non-renewed? ◯ YES ◯ NO
3. Has any malpractice claim or suit ever been brought against you? ◯ YES ◯ NO
4. Are you aware of any circumstances which may result in a malpractice claim or suit including sexual misconduct; or professional impropriety being made, or brought against you; or during the past twenty-four (24) months have any of your clients or patients in your care died; or did any sustain serious injury; or cause any property damage? ◯ YES ◯ NO
5. Do you provide any therapies, services, or activities that involve Equine Therapy and/or Canine Therapy? ◯ YES ◯ NO
   PLEASE NOTE: All therapies, services, or activities that involve Equine Therapy and/or Canine Therapy are excluded from all Preferra Risk Retention Group Inc. Claims-Made Liability policies. For additional information about these exclusions or policy coverages please call 1.888.278.0038.
6. Do you or any of your employees provide any of the following services? ◯ Adoption or foster care ◯ Legal proceedings, esp. mitigation investigation pre- and post-trial ◯ Mental health services for sex offenders or sexual addiction ◯ In-home or respite care ◯ Residential treatment ◯ Embryonic placement ◯ Psychiatric services
7. Do you utilize volunteers? ◯ YES ◯ NO

If your answer to any of the questions is "YES," please provide a detailed explanation on a separate sheet and include any pertaining documentation from a licensing board, ethics committee, professional association, or health care facility (e.g. complaint, dismissal letter, consent agreement, or pertinent court documents).

8. PLEASE READ, SIGN, AND DATE

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 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. **I have read/acknowledged the coverage information in this application.**

Signature of Owner/Partner/Principal Today's Date

ADDITIONAL INSUREDS

Please complete if any Additional Insureds are selected in Section 7:

LANDLORD

NAME OF LANDLORD	ADDRESS OF LANDLORD	LEASED ADDRESS

ALL OTHERS

NAME OF ADDITIONAL INSUREDS	ADDRESS OF ADDITIONAL INSUREDS
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Preferra Insurance Company RRG

AGENCY RENEWAL SUPPLEMENT FOR PROFESSIONAL LIABILITY INSURANCE

If you have questions, please call the Preferra RRG Plan Administrator: **888.278.0038**
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Please complete the following information. After an application is approved by underwriting, pricing information will be available.

SECTION I: AGENCY AND OPTIONAL COVERAGE INFORMATION

1. What were the gross revenues for the agency last year? _____

SECTION II: UNDERWRITING AND STAFF INFORMATION

2. What is the total number of hours donated by volunteers in an average work week? _____
   Is a documented training program available for volunteer training? ◯ YES ◯ NO If YES, please provide a copy with the application.
3. What is the average number of students working under the direction of agency personnel? _____
4. How many independent contractors are used by the agency? _____
5. The agency is certified by: _____ What year was the agency established? _____
6. Please list each W-2 employee or independent contractor, providing the following information:

A. Name_____ Job Title _____ Degree _____
Field of Study _____ Licensed or Certified as: _____ ◯ Full ◯ Part ◯ Owner ◯ Independent Contractor

B. Name_____ Job Title _____ Degree _____
Field of Study _____ Licensed or Certified as: _____ ◯ Full ◯ Part ◯ Owner ◯ Independent Contractor

C. Name_____ Job Title _____ Degree _____
Field of Study _____ Licensed or Certified as: _____ ◯ Full ◯ Part ◯ Owner ◯ Independent Contractor

D. Name_____ Job Title _____ Degree _____
Field of Study _____ Licensed or Certified as: _____ ◯ Full ◯ Part ◯ Owner ◯ Independent Contractor

E. Name_____ Job Title _____ Degree _____
Field of Study _____ Licensed or Certified as: _____ ◯ Full ◯ Part ◯ Owner ◯ Independent Contractor

F. Name_____ Job Title _____ Degree _____
Field of Study _____ Licensed or Certified as: _____ ◯ Full ◯ Part ◯ Owner ◯ Independent Contractor

Please attach additional pages if needed.

7. Do you or your entity conduct any activities that support or provide adoption services? ◯ YES ◯ NO If YES, complete Supplement I Underwriting Addendum.
8. Do you or your entity conduct any activities that support or provide foster care services? ◯ YES ◯ NO If YES, complete Supplement II Underwriting Addendum.
9. Do you or your employees provide services to clients in their homes more than 80% of your agency professional consult hours? ◯ YES ◯ NO
   If YES, please briefly explain the in-home services provided: _____

SECTION II: UNDERWRITING AND STAFF INFORMATION *continued*

10. Does your agency provide any residential care professional services? ◯ YES ◯ NO
(The policy pertaining to this application excludes liability coverage for entities with residential services.)

11. Does the agency maintain facilities for detoxification of substance abuse? ◯ YES ◯ NO
If YES, please describe: _____

_____

_____

_____

12. Number of client visits last year: _____

13. What types of problems are treated by the agency? _____

_____

_____

Please provide the web address for your organization: _____

If a website is not available, please provide a pamphlet describing your services or a written description providing the services and modalities used to achieve solutions for your clients.

14. Does the agency provide hotline services? ◯ YES ◯ NO If YES, please provide a detailed document outlining the personnel utilization and coverage for the services, as well as written documentation outlining the training provided.

15. Does the agency provide group therapy sessions? ◯ YES ◯ NO
If YES, please describe the format and average group size: _____

_____

_____

_____

16. Are you aware of any circumstances which may result in a malpractice claim or suit including sexual misconduct; or professional impropriety being made, or brought against you; or during the past twenty-four (24) months have any of your clients or patients in your care died; or did any sustain serious injury; or cause any property damage? ◯ YES ◯ NO

SECTION III: NOTICES

Notice to Arkansas Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a settlement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

Notice to Kentucky Applicants: 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.

Notice to Maine Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

SECTION III: NOTICES *continued*

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

SECTION IV: PLEASE READ, SIGN, AND DATE

The applicant hereby represents and warrants that the statements in this application are true. If the information provided on this application changes between the date of this application and the date on which this policy is intended to be issued, the applicant shall immediately notify the Preferra RRG Insurance Company.

I hereby warrant and represent that the facts and information stated in this agency application are true as of the date hereof: _____

Printed Name	Title	Signature