

Alliance of Nonprofits for Insurance

Social Service Professional Liability Supplemental Application

Applicant Name:						
Quote Need by Date:	Prop. Effective Date:					
Limits Requested:						

Please Note: This application is for Social Service Professional Liability coverage, and can only be bound in conjunction with a General Liability policy.

SOCIAL SERVICE PROFESSIONAL LIABILITY (SSP)

 Indicate the number of professionals that currently work as Employees, Volunteers, and Independent Contractors in the following professional capacities:
 If none, please check here: None

Emp		oyees	Volu	Volunteers		Independent Contractors	
Provider	FT	PT	FT	PT	FT	PT	
Acupuncturist							
Adoption Service Employee							
Aide							
Assisted Living Provider							
Certified Enrollment Counselor							
Childcare Worker							
Chiropractor							
CNA/LPN/Nurse Assistant							
Coach/Assistant Coach							
Companion Care/Home Aide							
Daycare Provider							
Dental Hygienist/Assistant							
Educator/Instructor/Teacher							
Group Home/Supported Living Provider							
Home Health Aide (greater skill than Companion)							
Intake Coordinator/Specialist							
Mentor/Tutor							
Nutritionist/Dietician							
Optician							
Personal Care Attendant							
Phlebotomist							
Psychologist/Psychotherapist							
Recreational Instructor							
RN							
Social Worker/Case Worker							
Therapist/Counselor (All)							
Veterinarian							
Other Professionals (describe):							

lf none, please check here: 🗌 l	None					
Madiaal Camiaaa Dravidar	Emp	oloyees	Vo	lunteers	Independent	Contractors
Medical Services Provider	FT	PT	FT	PT	FT	PT
Dentist						
Nurse Anesthetist, Midwife and/or Nurse Practitioner						
Optometrist						
Paramedic/EMT						
Pharmacist						
Physician Assistant					_	
Physician/Surgeon/Psychiatrist						
Note: Our policy may extend vica services rendered on the insured medical malpractice insurance w Does Applicant use any indepe	l's behalf or ith a minim	nly if the abov um limit of lia	e employed	or volunteer p		
If yes:						
a. Does Applicant require ther	n to sign a l	hold harmless	s or indemni	fication agree	ment?	🗌 Yes 🗌
b. Does Applicant require and contractor reflecting minimu				nce for each i	ndependent	🗌 Yes 🗌
c. Does Applicant require that Additional Insured on their i			ors name yo	our organizatio	on as an	🗌 Yes 🗌
endorsement to cover independ indicate here and attach a lis each independent contractor/10 Does Applicant provide services	st including 99 worker. s to bi-polar	the first and I	ast name ar tistic, schizo	nd a description phrenic, para	on of services p	brovided by
psychotic, severely mentally ill o If yes, please provide details:	lients or to	adjudicated s	sex offender	s?		🗌 Yes 📘
What security is provided for pro	otection and	d/or monitorin	a of Applica	nt's clients/re	sidents?	
	Video Cam		ther (describ			
What method does Applicant us			•			
Does Applicant diagnose clients			agitated one			☐ Yes [
			o/rooidonto?			
Does Applicant prescribe or provide medication to clients/residents?				Yes		
If yes, please provide details:						
 Does Applicant verify licenses a	nd other cr	edentials of s	taff before h	nirina?		Yes 🗌
a. If no, please explain:				J		
· · · ·	ice to verify	current licen	ses are mai	ntained and ir	a and standing	
b. If yes, are procedures in place to verify current licenses are maintained and in good standing Does Applicant have a formal incident procedure in place that requires staff to report to an					9: 103 _	
administrator all incidents that n	nay result ir	n a claim?	e mai requi	es stall to rep		Yes [
If yes, is a written record kept a		d regularly?				Yes [
Has Applicant or Applicant's sta						
a. Been reprimanded, refused agency?	admission	or suspende	d by any ass	ociation or ad	Iministrative	🗌 Yes 🗌
 Had their license been under placed under conditional state 		tion, suspend	ed, revoked	, voluntarily s	urrendered or	🗌 Yes [

If yes to either 11.a. or 11.b. above, please provide details:

12.	Do	es Applicant provide home health services?	🗌 Yes 🗌 No		
	lf y				
	a.	Require written plan by attending physician of clients prior to being accepted for home health services?	🗌 Yes 🗌 No		
		If no, please explain:			
	b.	🗌 Yes 🗌 No			
	c.	ving?			
		1) Medical record documentation?	🗌 Yes 🗌 No		
		2) Incident reporting?	🗌 Yes 🗌 No		
		3) Employee training?	🗌 Yes 🗌 No		
		4) Handling of complaints?	🗌 Yes 🗌 No		
		5) When providers should contact a physician?	🗌 Yes 🗌 No		
		6) Client care home visits documentation?	🗌 Yes 🗌 No		
		7) Clients no longer meet the criteria for home care?	🗌 Yes 🗌 No		
		8) Clients should be transferred to a hospital?	🗌 Yes 🗌 No		
	If no to any of 12.c., please explain:				

Claims and Insurance Information

13.	3. Has Applicant had any claims and/or incidents in the past three (3) years?								
	We require currently valued loss runs for the past three (3) years as well as a completed ANI Claims Supplemental Application for each claim that has been reported under any Professional Liability policy. If no coverage was in force, but a claim was made or an incident did occur, complete the Claims Supplemental Application to describe each incident.								
14.	. Does Applicant have knowledge or information of any incident which might give rise to a claim? 🗌 Yes 🗌 No								
	If yes, please explain:								
15.	5. Has any insurance carrier declined to issue a Professional Liability policy to Applicant?								
	If yes, please explain:								
16.	6. Has any insurance carrier canceled or non-renewed any of Applicant's Professional Liability coverage?								
	If yes, please explain:								
17.	7. Does Applicant currently have any Professional Liability coverage in force?								
	a. If yes, please complete the following:								
	Company	Effective Dates	Limits of Liability	Deductible	Annual Premium				
	b. If yes, is current Professional Liability coverage written on a claims-made basis?								
	c. If yes to 17.b. above, indicate current Retroactive Date:								

Signatures

 The undersigned is an authorized representative of the Applicant and certifies that reasonable inquiry has been made to obtain the answers to questions on this application. He/she certifies that the answers are true, correct and complete to the best of his/her knowledge.

 Applicant's Signature
 Date

 Print or type Applicant's name
 Applicant's Title