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