

## Human Services Application

<b>Applicant Information</b>	<i>For office use only: Approved</i> _____ <i>Effective Date:</i> _____
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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. 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

3. Are you a member of a professional association?  Yes    No   If yes, please specify: \_\_\_\_\_

**Professional Liability**

4. Rating Basis for limits of \$1,000,000 each occurrence/\$3,000,000 aggregate  
**\*\*\*\*List only W-2 Employees and/or Volunteers\*\*\*\***

Occupation	Number of Employees and/or Volunteers	Occupation	Number of Employees and/or Volunteers
Clerical /Admin		Educator	
Counselor		Social Worker	
Psychologist (Doctoral Level)		Speech Pathologist	
LEP/ Masters Psychologist		Dietician/ Nutritionist	
Marriage & Family Therapist		RN/LPN/LVN	
Occupational Therapist		Paraprofessional*	
BCBA/BCABA		Student	
Behavior Therapist		Other (Describe)*:	

**\*Please provide a job description for each "Paraprofessional" and/or "Other" designation on separate sheet.**

**Total Number of Employees/Volunteers:** \_\_\_\_\_ (should total amounts designated above)

**Additional Insureds**

5. If you have contracts requiring you list entities on your policy as Additional Insureds, **please provide their name and mailing address on a separate sheet**. If adding a landlord, also provide the physical address of the premises being leased.

- **Landlord** (you must have a written lease naming them as Lessor): **No additional charge\***  
\*Limited to 1 Lessor per office location, each additional is 10%
- **All Others** (please indicate the nature of your professional relationship in your written request e.g. agencies, employers, supervisors, property managers, etc.): **Additional 10% of your professional liability premium each**

**State licensing Board Defense Coverage Increase**

6. 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 limit to \$75,000 (\$75.00 additional premium)  
 Increase this limit to \$100,000 (\$100.00 additional premium)

**Supplemental Coverages**

7. a. I would like to ADD the CPH TOP® (Includes General Liability AND \*Property Coverage) .....  Yes  No  
NOT AVAILABLE in Florida

-- OR --

b. I would like to ADD ONLY General Liability Coverage.....  Yes  No

c. (if a or b is yes):

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

\*\*If yes, please provide an explanation on a separate sheet of paper

d. 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.

**Location 1 (If different from address in section 1)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total Square Footage Occupied by Applicant: \_\_\_\_\_

Monetary Value of Business Personal Property: \_\_\_\_\_

**Location 2**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total Square Footage Occupied by Applicant: \_\_\_\_\_

Monetary Value of Business Personal Property: \_\_\_\_\_

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

I would like to add this coverage

Do you provide background checks for all employees? .....  Yes  No

Do you have a contract requiring this coverage? If so, please provide a copy .....  Yes  No

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

I would like to add this coverage

Do you provide transportation to clients? .....  Yes  No

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

→ 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.

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

I would like to add this coverage

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

**Qualification Questions**

- 11. 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
- 12. 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
- 13. Have you or any of your employees ever been convicted of a misdemeanor or felony? .....  Yes  No
- 14. 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? Have you or any of your employees received a citation or paid a fine as a result of a board proceeding? Have you or any of your employees surrendered, either voluntarily or otherwise, your license, certification, or registration? ..... Yes  No
- 15. Have you or any of your employees ever been accused of sexual misconduct or any professional impropriety?..... Yes  No
- 16. 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
- 17. 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
- 18. The following question MUST be answered if you employ an RN, LVN, LPN, Nurse Practitioner or Clinical Nurse Specialist:  
Does your nursing staff provide OB/GYN, Neonatal, Cosmetics, or Aesthetic services? .....  Yes  No

**If your answer to any of the questions is “yes”, please provide a detailed explanation on a separate sheet and any pertaining documentation.**

**PLEASE SIGN AND DATE THE CONFIRMATION ON PAGE 4**

Thank you for choosing CPH & Associates!

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

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*Office Hours:*

*Monday - Friday 8:30 AM-5 PM*

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

***E-mail:*** [applications@cphins.com](mailto:applications@cphins.com) ***Website:*** [www.cphins.com](http://www.cphins.com)

Confirm: Please Read, Sign & Date Below

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company \* in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

\*Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company

#### FRAUD NOTICE STATEMENTS

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 AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS (\$5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). (NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).

**APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV:** ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

**APPLICABLE IN COLORADO:** 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.

**APPLICABLE IN FLORIDA AND OKLAHOMA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

**APPLICABLE IN KANSAS:** AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

**APPLICABLE IN KENTUCKY:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON:** 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 A DENIAL OF INSURANCE BENEFITS.

**APPLICABLE IN NEW YORK:** 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

\_\_\_\_\_  
INSURED NAME (PLEASE PRINT/TYPE)

\_\_\_\_\_  
TITLE (MUST BE SIGNED BY THE GROUP OWNER, PARTNER, OR PRINCIPAL)

\_\_\_\_\_  
INSURED SIGNATURE

\_\_\_\_\_  
DATE

#### SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER: **CPH & Associates**

(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY: **CPH & Associates**

PRODUCER LICENSE NUMBER: **19193**

(If this is a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS: **711 S. Dearborn St., Suite 205, Chicago, IL 60605**