FAIR AMERICAN INSURANCE AND REINSURANCE COMPANY

PSYCHIATRISTS' PROFESSIONAL LIABILITY INSURANCE PROGRAM

PRACTICE STRUCTURE/VICARIOUS LIABILITY COVERAGE

IMPORTANT:

- **A copy of the articles of incorporation must accompany the application.**
- **A copy of all written agreements which establish the identity of the partnership must accompany the application.**
- **Prior to answering any questions referring to any employees, independent contractors, partners, or shareholders, please inquire of each of these individuals as to whether they have information pertinent to the question.**

(Please print or type all requested information.)

Full Name:_____ Customer ID Number:_____

1. **Practice Structure:**

☐ Employer of other Professionals
☐ Contractor of the services of other professionals
☐ Professional Corporation with more than one shareholder
☐ Incorporated Solo Private Practice
☐ Professional Partnership/Association
☐ Fictitious Name Entity or DBA
☐ Joint Venture or LLC

2. **Limit of Liability requested:**

☐ Shared Limit of Liability with the Named Insured ☐ Separate Limit of Liability from the Named Insured

Note: Shared limits not available for: IN, KS, LA, PA, WI

3. **Name of the Professional Corporation, Partnership, Practitioner with Employees/Independent Contractor Professionals, Fictitious Name Entity or DBA:** _____

(Note: Coverage is not available to business corporations.)

4. **Practice Address** *(Not previously listed. Please attach a separate sheet for additional locations.)*

Street:_____City/State/Zip:_____

Telephone:_____ Fax:_____

Do you want a Certificate of Insurance sent to this location? ☐ Yes ☐ No

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5. Does the Professional Corporation, Partnership, Sole Practitioner, or Fictitious Name Entity have any ownership interest in a hospital, nursing home, sanitarium, clinic, laboratory, any facility providing bed and board, and/or any other business enterprise? ***(No coverage is provided for ownership or administrative activities related to the above.)*** ☐ Yes ☐ No

6. Is the Professional Corporation, Partnership, Sole Practitioner, or Fictitious Name Entity in the business of managing or providing staffing to a hospital, nursing home, sanitarium, clinic, laboratory, any facility providing bed and board, and/or any other business enterprise? ***(No coverage is provided for management/administrative activities related to the above.)*** ☐ Yes ☐ No

7. Has the Professional Corporation, Partnership, Sole Practitioner, or Fictitious Name Entity been involved in a malpractice suit or claim (pending or closed) in the past seven years? **If yes**, please complete the Claims History supplemental application and attach copies of all pertinent documentation. ☐ Yes ☐ No

8. Have any claims or incidents **ever** been reported involving any of your employee/independent contractor professionals, partners and/or shareholders to any carrier? **If yes**, please complete the Claims History supplemental application and attach copies of all pertinent documentation. ☐ Yes ☐ No

9. Have any of your partners, shareholders, employee/independent contractor professionals **ever** been the subject of an investigation or disciplinary proceedings? **If yes**, please provide copies of all pertinent documentation and a detailed written explanation. ☐ Yes ☐ No

10. Have any of your partners, shareholders, employee/independent contractor professionals **ever** been charged with, convicted of, pleaded guilty or no contest to a felony? **If yes**, please provide copies of all pertinent documentation and a detailed written explanation. ☐ Yes ☐ No

11. Has the Professional Corporation, Partnership, Sole Practitioner, or Fictitious Name Entity **ever** had a settlement or judgment alleging undue familiarity, professional misconduct or assault in connection with undue familiarity? **If yes**, please complete the Claims History supplemental application and attach copies of all pertinent documentation. ☐ Yes ☐ No

SUPPLEMENTAL APPLICATION

12. Have any of your partners, shareholders, employee/independent contractor professionals **ever** had a settlement or judgment alleging undue familiarity, professional misconduct or assault in connection with undue familiarity? **If yes**, please complete the Claims History supplemental application and attach copies of all pertinent documentation. ☐ Yes ☐ No

In order for coverage to apply, all shareholders and partners are required to carry their own individual professional liability insurance with limits of liability equal to or in excess of your coverage limits of liability. Additionally, a minimum of 50% of all licensed physician shareholders or partners must be insured with The Psychiatrists' Program.

13. Partners and Shareholders Information:
Total number of Partners or Shareholders: _____

a) Name: _____ Degree:_____

Practices As: _____ Date of Hire: _____

Insurance Carrier: _____ Coverage Limits of Liability:_____

If insured with our program, please provide the Customer ID#: _____

b) Name: _____ Degree:_____

Practices As: _____ Date of Hire: _____

Insurance Carrier: _____ Coverage Limits of Liability:_____

If insured with our program, please provide the Customer ID#: _____

c) Name: _____ Degree:_____

Practices As: _____ Date of Hire: _____

Insurance Carrier: _____ Coverage Limits of Liability:_____

If insured with our program, please provide the Customer ID#: _____

In order for coverage to apply, all employee/independent contractor professionals are required to carry their own individual professional liability insurance with limits of liability equal to or in excess of your coverage limits of liability. Additionally, a minimum of 50% of all licensed physicians must be insured with The Psychiatrists' Program.

14. Employee/Independent Contractor Professionals Information:
Total number of Employees/Independent Contractors: _____

a) Name: _____ Degree:_____

Practices As: _____ Date of Hire: _____

Insurance Carrier: _____ Coverage Limits of Liability:_____

If insured with our program, please provide the Customer ID#: _____

b) Name: _____ Degree:_____

Practices As: _____ Date of Hire: _____

Insurance Carrier: _____ Coverage Limits of Liability:_____

If insured with our program, please provide the Customer ID#: _____

c) Name: _____ Degree:_____

Practices As: _____ Date of Hire: _____

Insurance Carrier: _____ Coverage Limits of Liability:_____

If insured with our program, please provide the Customer ID#: _____

DECLARATIONS

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA 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 AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: 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 THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

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 LOUISIANA 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 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 A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY 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 MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

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 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 OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Physician's Personal Signature

Date

The Psychiatrists' Program
1401 Wilson Boulevard, Suite 700
Arlington, VA 22209

Name of Agent: _____

License #: _____

Signature: _____

Date: _____