NONPROFITS INSURANCE ALLIANCE OF CALIFORNIA
Part of Nonprofits Insurance Alliance (NIA)

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Financial Strength A M BEST A Excellent

NIAC #3

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. For complete instructions on our submission requirements, please visit https://secure.insurancefornonprofits.org/Brokers-New-Submissions.cfm

SOCIAL SERVICE PROFESSIONAL LIABILITY (SSP)

1. 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

Provider	Employees		Volunteers		Independent Contractors	
	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):						

2. Indicate number of Annual Medical Professional Staffing – Employees, Volunteers and Independent Contractors working for Applicant in the following medical professional capacities:

If none, please check here: ☐ None

Medical Services Provider	Employees		Volunteers		Independent Contractors	
	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 vicarious professional coverage to the nonprofit entity as respects professional services rendered on the insured's behalf only if the above employed or volunteer professionals carry their own medical malpractice insurance with a minimum limit of liability of $1,000,000.

3. Does Applicant use any independent contractors? ☐ Yes ☐ No

If yes:

a. Does Applicant require them to sign a hold harmless or indemnification agreement? ☐ Yes ☐ No

b. Does Applicant require and maintain on file certificates of insurance for each independent contractor reflecting minimum limits of liability of $1,000,000? ☐ Yes ☐ No

c. Does Applicant require that all independent contractors name your organization as an Additional Insured on their insurance policy? ☐ Yes ☐ No

Note: Typically, independent contractors/1099 workers are expected to procure their own insurance. Independent contractors/1099 workers are not covered under the policy for which Applicant is applying unless a special endorsement is added to the policy. If you would like us to consider adding this special endorsement to cover independent contractors/1099 workers providing services on your behalf, please indicate here ☐ and attach a list including the first and last name and a description of services provided by each independent contractor/1099 worker.

4. Does Applicant provide services to bi-polar, severely autistic, schizophrenic, paranoid, psychotic, severely mentally ill clients or to adjudicated sex offenders? ☐ Yes ☐ No

If yes, please provide details: _____

5. What security is provided for protection and/or monitoring of Applicant's clients/residents?

☐ None ☐ Guards ☐ Video Cameras ☐ Other (describe): _____

6. What method does Applicant use for de-escalation with agitated clients? _____

7. Does Applicant diagnose clients/residents? ☐ Yes ☐ No

8. Does Applicant prescribe or provide medication to clients/residents? ☐ Yes ☐ No

If yes, please provide details: _____

_____

9. Does Applicant verify licenses and other credentials of staff before hiring? ☐ Yes ☐ No

a. If no, please explain: _____

b. If yes, are procedures in place to verify current licenses are maintained and in good standing? ☐ Yes ☐ No

10. Does Applicant have a formal incident procedure in place that requires staff to report to an administrator all incidents that may result in a claim? ☐ Yes ☐ No

If yes, is a written record kept and reviewed regularly? ☐ Yes ☐ No

11. Has Applicant or Applicant's staff ever:

a. Been reprimanded, refused admission or suspended by any association or administrative agency? ☐ Yes ☐ No

b. Had their license been under investigation, suspended, revoked, voluntarily surrendered or placed under conditional status? ☐ Yes ☐ No

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

12. Does Applicant provide home health services? ☐ Yes ☐ No

If yes, does Applicant:

a. Require written plan by attending physician of clients prior to being accepted for home health services? If no, please explain: ☐ Yes ☐ No

b. Require all clients receiving any level of skilled care to have a current and regularly updated physician treatment plan on file? ☐ Yes ☐ No

c. Are written, enforced and monitored policies and procedures in place regarding the following?

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. Has Applicant had any claims and/or incidents in the past three (3) years? ☐ Yes ☐ No

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. Has any insurance carrier declined to issue a Professional Liability policy to Applicant? ☐ Yes ☐ No

If yes, please explain:

16. Has any insurance carrier canceled or non-renewed any of Applicant's Professional Liability coverage? If yes, please explain: ☐ Yes ☐ No

17. Does Applicant currently have any Professional Liability coverage in force? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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.

Notice: This risk pooling contract is issued by a pooling arrangement authorized by California Corporations Code Section 5005.1. The pooling arrangement is not subject to all of the insurance laws of the State of California and is not subject to regulation by the Insurance Commissioner. Insurance guaranty funds are not available to pay claims in the event the risk pool becomes insolvent.

Applicant's Signature	Date	Producer's Signature	Date
Print or type Applicant's name		Applicant's Title	