Complete Equity Markets, Inc.

APPLICATION FOR PSYCHOTHERAPIST
PROFESSIONAL LIABILITY INSURANCE

(THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY)

PLEASE TYPE OR PRINT CLEARLY IN INK. ANSWER ALL QUESTIONS COMPLETELY FAILURE TO ANSWER ALL QUESTIONS WILL DELAY OUR ABILITY TO PROCESS THIS APPLICATION.

IMPORTANT: YOU ARE NOT ELIGIBLE FOR COVERAGE UNDER OUR PROGRAM IF ONE OR MORE OF THE FOLLOWING APPLY TO YOU:

A. You use hypnotherapy to assist clients in recovering failed or repressed memories of possible abuse; AND/OR,
B. You have engaged in sexual activity with a client or a spouse, family member, or significant other of any client; AND/OR,
C. You have been convicted of a crime, other than minor traffic offenses in any state or country.

1. Name of Applicant: _____

2. Complete Address: _____

   Phone: (_____)_____ Fax: (_____)_____ E-Mail: _____

   Mailing Address:_____

3. Please describe all services you provide: _____

4. Applicant is:_____

   ☐ Licensed as a _____ License #_____
   ☐ Certified as a _____ Certificate #_____
   ☐ Registered as a _____ Registration #_____
   ☐ Supervised as a _____

5. Are you licensed, certified, registered or supervised in all jurisdictions where you are providing services? □Yes □No

   If No, please describe all services you provide: _____

   _____

6. Do you comply with the ethical and professional standards set by any applicable Board of Examiners, Regulatory Board or Peer Review Board in all jurisdictions where you provide services? □Yes □No

7. Degree you are practicing under:

   □No Degree □Associate □Bachelor

   □Masters □Education Specialist □Doctorate

8. In what field of study is your highest degree? _____

9. Are you self-employed or are you employed by others? _____

   If you are employed by others, please give details of your employer. _____

10. What are the number of client visits per year? _____

11. Do you use any independent contractors or consultants, or supervise anyone whose services are in the mental health field and/or for whom you do billing, share fees with or in any way derive income from the relationship? □Yes □No

If Yes, please list the names and professional credentials of each one.

Name	Degree	Field of Study	Lic. State	Title

Do you verify that all individuals listed above carry professional liability insurance? □Yes □No

All independent contractors, consultants or supervised charges must be included. You will be covered for their acts but they will not be insured under your policy. They must carry their own insurance.

12. What is your income? Last year: _____ This year: _____Projected income next year:_____

13. Do you share office space with any other mental health practitioners? □Yes □No

If Yes, do all practitioners carry their own professional liability insurance? □Yes □No

14. Have any claims been made against you in the last 5 years, in respect of your activities described above? □Yes □No

If Yes, please give full details: _____

15. Are you aware of any circumstances that could lead to a claim against you in the last 5 years, in respect of your activities described above? □Yes □No

If Yes, please give full details: _____

_____

16. Have any complaints been made against you in the last 5 years, in respect of the activities described above with any licensing, supervisory, regulatory or peer review bodies? □Yes □No

If Yes, please give full details: _____

_____

17. Has any insurance company cancelled, declined to renew, or refused professional liability insurance to you? □Yes □No
If Yes, please attach details.

18. Have you ever been accused of sexual misconduct or impropriety? □Yes □No
If Yes, please attach details.

19. Do you currently carry Professional Liability Insurance? □Yes □No
If Yes, please give details:

Insurer	Premium	Limits	Deductible

20. What limits of liability do you desire?

□$250,000 □$500,000 □$1,000,000 □$3,000,000

Deductible is $1,000

21. Are you a member in good-standing of the American Psychotherapy Association? □Yes □No

*** PLEASE INCLUDE A COPY OF YOUR RESUME ***

WARRANT: I/WE WARRANT THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND THAT IT SHALL BE THE BASIS OF THE POLICY OF INSURANCE AND DEEMED INCORPORATED THEREIN. SHOULD THE UNDERWRITERS EVIDENCE THEIR ACCEPTANCE OF THIS APPLICATION BY ISSUANCE OF A POLICY, I/WE HEREBY AUTHORIZE THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURER TO UNDERWRITERS.

NOTE: IN APPLYING FOR COVERAGE, THE APPLICANT AGREES THAT IN THE EVENT OF COVERED LOSSES, HE WILL BE REQUIRED TO BE DEFENDED BY THE UNDERWRITERS' APPOINTED LAWYERS AND THAT THE DEDUCTIBLE SHALL APPLY TO LOSS AND CLAIM EXPENSES, ADJUSTING EXPENSES, INVESTIGATIVE COSTS AND LEGAL FEES. IF THE APPLICANT ELECTS TO HANDLE A CLAIM WITHOUT IN ANY WAY INVOLVING THE UNDERWRITERS, THEN NO COVERAGE FOR SUCH CLAIM IS AFFORDED THE APPLICANT UNDER THE POLICY.

I UNDERSTAND AND ACCEPT THAT THE POLICY APPLIED FOR PROVIDES COVERAGE ON A CLAIMS MADE BASIS FOR ONLY THOSE CLAIMS MADE AGAINST THE INSURED WHILE THE POLICY IS IN FORCE AND THAT THE COVERAGE CEASES WITH THE TERMINATION OF THE POLICY UNLESS I EXERCISE OPTIONS AVAILABLE AND IN ACCORDANCE WITH TERMS OF THE POLICY.

Signature of Applicant: _____

Title: _____

Date: _____

SIGNING THIS FORM AND TENDERING PREMIUM DOES NOT BIND THE APPLICANT OR THE UNDERWRITERS TO COMPLETE THE INSURANCE. APPLICATION MUST BE SIGNED TO BE CONSIDERED FOR QUOTATION.

The applicant or a partner of the firm must sign the Proposal Form duly completed, together with any supplementary information. One signed copy will be attached to and form part of the Policy or Certificate if issued. Completion of the Proposal Form does not bind or obligate the firm or the Underwriters to complete the insurance.

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