GenStar

Counseling Services Supplemental Application

Applicant's Instructions:

Answer all questions. If the answer to any question is NONE, please state NONE.
Do not use N/A or Not Applicable.

Applicant:

Proposed Effective Date: _____

Full name of all entities of the applicant: _____

_____

Principal address:

_____

Type of counseling services offered:

_____

Offenders Are: ____ Adult ____ Juvenile

What percentage of patients or clients is directed to you by the criminal justice system? : _____

Annual number of visits? _____ Annual number of group sessions? _____

Annual number of inmate visits in secured facilities? _____ Annual number of one-on-one contacts? _____

Are medical records for all patients and clients obtained in conjunction with counseling sessions? Yes ____ No ____

If no, please explain: _____

Does applicant own a 50% or greater interest in this operation? Yes ____ No ____

Employees:

	YES	NO	# OF FULL TIME	# OF PART TIME
Facility Administrators	☐	☐	_____	_____
Probation Officers	☐	☐	_____	_____
Psychologist's	☐	☐	_____	_____
Pharmacist's	☐	☐	_____	_____
Physicians, Psychiatrists or Physician's Assistants:	☐	☐	_____	_____
Counselors:	☐	☐	_____	_____
Registered Nurses / L.P.N.'s	☐	☐	_____	_____
Clerical Staff / Maintenance	☐	☐	_____	_____
Other:	☐	☐	_____	_____

Please describe all employees that are "Other": _____

Medical Personnel:

Please list all physicians, physician assistants and psychiatrists (all employed, volunteer or contracted)

1.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

2.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

3.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

4.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

5.

Name: _____ Specialty _____ Board Certified / Eligible? _____ License No._____

Hours per week: _____ Employed, Contracted or Volunteer? _____

Currently covered by Malpractice Insurance? _____ Carrier? _____

Please attach another sheet if space provided above is insufficient

Please note that the coverage being applied for provides no Medical Malpractice protection for Physicians, Physician Assistants and/or Psychiatrists.

FRAUD WARNING

Notice to Applicants of all states except Colorado, New York, and Pennsylvania

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

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 agencies.

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 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 Pennsylvania Applicants:
Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut, and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state. This information applies to General Star National Insurance Company in Connecticut only.

An authorized representative who is an active owner, officer, or partner of your firm must sign this Application within thirty (30) days prior to the policy inception date.

Signature: _____ Title: _____
(Owner, Partner or Officer)

Date: _____

THE APPLICANT UNDERSTANDS THAT COMPLETION OF THIS APPLICATION NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.