RESET SAVE PRINT

Supplemental Application

Include all of the following with this completed & signed renewal questionnaire:

☐ Completed ACORD Applications ☐ Updated statements of value ☐ Updated schedule of vehicles/driver list

A. INSURED INFORMATION

Insured Name: _____ Policy Number: _____

Contact Person: _____

Email Address: _____

1. ☐ 'X' here if there have been no changes in operation during this year OR

   Describe changes in operations or programs during this past year. Include any changes, additions, deletions of operation(s), programs, or internal policies, including types of clients served (use additional pages if necessary, reference websites, brochures, etc…)

   _____

   _____

   _____

   _____

2. Has there been a change in management this year? ☐ Yes ☐ No
3. If licensed, is your license current and in good standing? ☐ Yes ☐ No
4. Were there any violations or deficiencies noted during the last inspection performed by the licensing agency? ☐ Yes ☐ No

   If Yes, please explain:

   _____

   _____

5. Are you aware of any claims, allegations, and/or incidences (including abuse & molestation) made against your organization, or against anyone working on your behalf in the past five (5) years that may give rise to a claim? ☐ Yes ☐ No

B. PROFESSIONAL LIABILITY

1. Do you have any employed, contracted or volunteer Nurse Practitioners? ☐ Yes ☐ No

   If Yes, how many? _____

   a. Do all of your Nurse Practitioners Prescribe medication? ☐ Yes ☐ No

      If Yes, how many Nurse Practitioners prescribe medication? _____

      Work in non-medical positions within the scope of the Human Services organization such as managers, educators, directors, nursing duties? ☐ Yes ☐ No

      If No, describe duties: _____

   b. Do your Nurse Practitioners provide services to individuals other than your clients? ☐ Yes ☐ No

      If Yes, please explain: _____

2. Does the Insured use employed, contracted, or volunteer Medical Professionals? ☐ Yes ☐ No

If Yes, complete the following:

a. Are any Psychiatrists/Nurse Practitioners a member of American Academy of Child & Adolescent Psychiatry (AACAP) ☐ Yes ☐ No

b. Does any Psychiatrist/MD or Nurse Practitioner perform any clinical or pharmaceutical research on clients? ☐ Yes ☐ No

If Yes, please explain: _____

c. Does the MD/Nurse Practitioner get informed consent prior to prescribing medications? ☐ Yes ☐ No

d. Please complete the table below for any psychiatrists, MDs, Nurse Practitioners, Dentists or Optometrists.

NAME	Dr. _____	Dr. _____	Dr. _____
Specialty			
Board Certified or Eligible			
Years in Practice			
License Number			
Hours p/wk for Insured			
Employed or Contracted?			
Does physician/Nurse Practitioner carry own Malpractice insurance?****			
If Yes, does coverage include acts while working for this agency?			
If Yes, does coverage include Contingent Coverage for this agency?			
Any claims in past 5 years?			

****Provide Certificate of Medical Malpractice for each Psychiatrist or Physician and Nurse Practitioner

3. Do you practice cyber counseling? ☐ Yes ☐ No

If Yes, please answer the following:

a. List states you where currently and plan to practice: _____

b. Do you follow the ACA Code of Ethics? ☐ Yes ☐ No

c. Do you utilize specialized software to monitor sessions? ☐ Yes ☐ No

If Yes, please provide name: _____

d. Please provide total number of Cyber Counselors: Full time: _____ Part time: _____

Are all licensed? ☐ Yes ☐ No

If not, how many are not licensed in Cyber Counseling? Full time: _____ Part time: _____

e. Please provide Cyber Counseling client count: Current year: _____ Expected next year: _____

4. Indicate the number of staff (please complete the following table)

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Administrator								
Child Case Worker								
Clergy								
Clerical/Office Staff								
Counselor (other)								
Home Health Aide								
Nurse Practitioner								

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Nurse—LPN								
Nurse—RN								
Nutritionist								
Physician								
Psychiatrist								
Psychologist								
Resident Manager								
Social Worker—Bachelors (BSW)								
Social Worker—Masters (MSW)								
Teacher/Tutor/Aide								
Therapist—Occupational								
Therapist—Physical								
Therapist—Speech/Hearing								
Other Positions (specify)								
Other Positions (specify)								

5. Indicate annual number of clients in each age range for all programs/services:

   0–8 years: _____ 9–18 years: _____ over 18 years: _____

6. Professional Liability Deductibles—Optional

   (Check one, if no option is selected, no deductible will apply)

   ☐ 1,000 ☐ 2,500 ☐ 5,000 ☐ 10,000 ☐ 25,000

PANDEMIC AND COMMUNICABLE DISEASE

1. Do you have formal procedures in place to handle pandemic or other communicable diseases? ☐ Yes ☐ No
   a. Do your procedures address:
      i. Staffing ☐ Yes ☐ No
      ii. Training ☐ Yes ☐ No
      iii. Personal protective equipment ☐ Yes ☐ No
      iv. Client care ☐ Yes ☐ No
      v. Vendors/visitors ☐ Yes ☐ No
      vi. Internal & external communication ☐ Yes ☐ No
      vii. Maintenance of premises and vehicles ☐ Yes ☐ No
      viii. CDC guidelines and recommendations ☐ Yes ☐ No
   b. Please provide a copy of your written procedures
2. Have you ever had to implement those procedures? ☐ Yes ☐ No
   a. If yes, please provide details. _____

DECLARATION AND SIGNATURE

Authorized Entity Representative Designation

The person named herein is authorized and designated to give and receive any and all notices on behalf of the entity and all Insureds from the entity or their authorized representative(s) concerning this insurance.

Named Individual: _____

Title/Position: _____ Date: _____

Attestation

The authorized signer of this application represents to the best of his/her knowledge and belief that the statements and information set forth herein are true and include all material information. The authorized signer also represents that any fact, circumstance or situation indicating the probability of a claim or legal action now known to any entity official or employee has been declared, and it is agreed by all concerned that the omission of such information shall exclude any such claim or action from coverage under the insurance being applied for. Signing of this application does not bind The Hanover Insurance Group, Inc. to offer, nor the authorized signer to accept insurance, but it is agreed this application and any attachments hereto shall be the basis of the insurance and will be incorporated by reference and made part of the policy should a policy be issued.

Signature of Authorized Entity Representative

_____ Date _____

The Hanover Insurance Group®

The Hanover Insurance Company
440 Lincoln Street, Worcester, MA 01653

hanover.com
The Agency Place (TAP)—https://tap.hanover.com

115-1132 (12/20)