



Flood and Peterson Care Association
THERAPIST AND COUNSELOR INSURANCE APPLICATION

SECTION 1: Name and Mailing Information

FULL NAME:

Trade Name if Applicable:

Mailing Address:

City:

State:

Zip:

Home Phone Number:

Cell Phone Number:

Email Address:

Please list any additional office locations on an attached sheet (if applicable)

Your Professional Service (Check all that apply)

<input type="checkbox"/>	Behavior Therapist	<input type="checkbox"/>	Special Education Specialist	<input type="checkbox"/>	Occupation Therapist
<input type="checkbox"/>	Cognitive Therapist	<input type="checkbox"/>	Speech Therapist	<input type="checkbox"/>	Rehabilitation Counselor
<input type="checkbox"/>	Early Intervention	<input type="checkbox"/>	Music Therapist	<input type="checkbox"/>	Art Therapist
<input type="checkbox"/>	Other:				

Section 2: Underwriting Questions (Circle Answers)

1. Are you currently licensed and/or certified and in good standing in the state for the Professions listed above. (If certifications are required)	Yes	No
2. Are you currently contracted with a placement agency, Community Centered Board or other State Funded organization? (This is required)	Yes	No
3. Have you ever been refused coverage for professional liability or malpractice or has your malpractice professional liability insurance ever been cancelled or declined for renewal?	Yes	No
4. Has any claim or lawsuit been filed against you for alleged malpractice or professional liability, or are you aware of any incident or existing circumstances that might reasonably lead to a claim or a suit? PLEASE EXPLAIN ANY YES ANSWERS attach additional pages if necessary)	Yes	No
5. Have you ever had your license, certification or registration suspended, revoked, or placed on probation by a licensing board of examiners, or any other governmental entity that regulates your profession?	Yes	No
6. Have you ever surrendered either voluntarily or otherwise, your license, certificate or registration?	Yes	No
7. Have you ever been accused of sexual misconduct or any professional impropriety? PLEASE EXPLAIN ANY YES ANSWERS attach additional pages if necessary)	Yes	No
8. Have any complaints ever been filed against you with a peer review committee or an ethics committee of a professional association, hospital, health care facility, licensing board, or any other governmental or private entity? PLEASE EXPLAIN ANY YES ANSWERS attach additional pages if necessary)	Yes	No
9. Do you know of any reason why you cannot comply with the legal, ethical, or professional standards set by law, by regulation, by a peer review committee or by an applicable code of ethics in any jurisdiction where you provide services?	Yes	No



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10. Do you have employees, or do you pay anyone to perform services for you?
(THIS PROGRAM IS FOR INDIVIDUAL THERAPISTS ONLY. COVERAGE DOES NOT EXTEND TO EMPLOYEES OR CONTRACTED THERAPISTS.)

Yes

No

General & Professional Liability Insurance Premium Due: **\$399.86***
***(\$388.21 premium plus \$11.65 Surplus Lines Tax)**

Make Check or Money Order Payable to Care Association

Mail to: PO BOX 578, Greeley, Colorado 80632

THE APPLICANT DECLARES THE ABOVE STATEMENTS AND REPRESENTATIONS ARE TRUE AND CORRECT AND THAT NO FACTS HAVE BEEN SUPPRESSED OR MISSTATED. THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE COMPANY TO SELL NOR THE APPLICANT TO PURCHASE THIS INSURANCE, BUT ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPRESENTATIONS MADE IN THIS APPLICATION AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

THE APPLICANT UNDERSTANDS THAT ANY COVERAGE PROVIDED PURSUANT TO THIS APPLICATION WILL BE PART OF A MASTER INSURANCE PROGRAM WITH A \$1,000,000 LIMIT OF LIABILITY PER CLAIM AND A MAXIMUM POLICY AGGREGATE LIMIT OF \$5,000,000 (THEREFORE, IT IS POSSIBLE THAT CLAIMS ASSOCIATED WITH OTHER HOST HOMES MAY PARTIALLY REDUCE OR ENTIRELY ELIMINATE LIMITS OF LIABILITY AVAILABLE TO YOU).

THE POLICY UNDER THIS PROGRAM IS A CLAIMS-MADE POLICY WHICH PROVIDES LIABILITY COVERAGE ONLY IF A CLAIM IS MADE DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD.

THE CONTRACT UNDER THIS PROGRAM IS DELIVERED AS A SURPLUS LINES COVERAGE UNDER THE "NONADMITTED INSURANCE ACT". THE INSURER ISSUING THE CONTRACT IS NOT LICENSED IN COLORADO BUT IS AN ELIGIBLE NON-ADMITTED INSURER. THERE IS NO PROTECTION UNDER THE PROVISION OF THE COLORADO INSURANCE GUARANTY ASSOCIATION ACT.

THERAPIST SIGNATURE: _____ DATE: _____

APPLICANT HAS READ AND UNDERSTANDS THE ABOVE INFORMATION AND REALIZES THERE WILL BE NO CANCELLATION REFUNDS

PAYMENT OPTIONS

You may complete your application for RENEWAL ONLINE at www.careassociation.net, credit or debit cards are accepted. If you need assistance with online applications, please contact our office at 303-333-0375. If you are submitting your application via mail, please attach a CHECK OR MONEY ORDER made payable to CARE ASSOCIATION. Any returned checks will be assessed at \$25.00 charge plus the premium payment. NO CANCELLATION REFUNDS will be issued even if contracts change mid-year. All applicants must be approved prior to binding coverage. Certificates of Insurance will be issued upon approval. If approval is denied, your payment will be returned to you within 15 days of denial.