CARE ASSOCIATION/CENTERPOINT INSURANCE GROUP
Therapist & Counselor Insurance Program

THERAPIST & COUNSELOR INSURANCE APPLICATION

Application Valid from: 03/01/2021 through 03/01/2022

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)

	Behavior Therapist		Special Education Specialist		Occupation Therapist
	Cognitive Therapist		Speech Therapist		Rehabilitation Counselor
	Early Intervention		Music Therapist		Art Therapist
	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**

CARE ASSOCIATION/CENTERPOINT INSURANCE GROUP
Therapist & Counselor Insurance Program

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**
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. IF YES, PLEASE CONTACT OUR OFFICE FOR FURTHER INFORMATION)**	**Yes**	**No**

General & Professional Liability Insurance Premium Due: **$350.00**
Make Check or Money Order Payable to Care Association
Mail to: 8400 E. Prentice Ave Suite 735
Greenwood Village, Co 80111

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 REPEPRESENTATIONS MADE IN THIS APPLICATION AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

FURTHERMORE, THE APPLICANT UNDERSTANDS THAT ANY COVERAGE PROVIDED BY THE COMPANY WILL BE PART OF A MASTER INSURANCE PROGRAM WITH A $1,000,000 LIMIT OF LIABILITY PER CLAIM AND A MAXIUMUM POLICY AGGREGATE LIMIT OF $5,000,000 (Effective 3/1/2021– 3/1/2022). THEREFORE, IT IS POSSIBLE THAT CLAIMS ASSOCIATED WITH OTHER COLORADO HOST HOMES MAY PARTIALLY REDUCE OR ENTIRELY ELIMINATE LIMITS OF LIABILITY AVAILABLE TO YOU. IT IS AGREED THAT SUCH COVERAGE AS IS AFFORDED BY SECTION 102(1) OF THE TERRORISM RISK INSURANCE ACT OF 2002 IS INCLUDED FOR NO PREMIUM CHARGED.

THERAPIST SIGNATURE: _____ DATE: _____

PAYMENT OPTIONS

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

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 attached 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 should 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.