Western World INSURANCE GROUP

Physical, Speech, Occupational & Respiratory Therapy
Supplemental Application
(Complete in addition to ACORD)

1. Name of Applicant: _____
2. Website Address: _____
3. List full name of individual or partners and their interests: _____

_____

4. What types of therapy are provided by you?
   ☐ Physical ☐ Speech ☐ Occupational ☐ Respiratory ☐ Other*
   *Please describe: _____
5. Please indicate your professional specialty and provide details of your training, licensing and certification: _____

_____

6. Are all services delivered by registered, certified, licensed or degreed personnel? ☐ Yes ☐ No
   If not, does one of the above directly supervise all services? ☐ Yes ☐ No
7. Please provide details of your operations and daily duties: _____

_____

8. a. If a "For-Profit", previous 12 months gross sales: $ _____
      Anticipated gross sales for policy period: $ _____
   b. If a "Not-For-Profit", previous 12 months outpatient visits: _____
      Anticipated outpatient visits for policy period: _____
      Annual operating budget: $ _____
9. Please indicate the percentage of time spent in the following work locations:
   ___% Assisted living facilities ___% Client's homes ___% Hospitals ___% Outpatient clinic
   ___% Nursing homes ___% Prisons ___% Schools ___% Other*
   *Please describe: _____

10. Please provide details of employed or contracted personnel:	Number Employed	Number Contracted
Chiropractors		
Massage Therapists		
Nurse Practitioners		
Physicians		
Physician's Assistants		
Therapists		
Therapy Assistants		
Other (describe): _____		

11. If involved with sports-related therapy, what level:
    ☐ High School ☐ College ☐ Semi-Pro ☐ Professional
12. Is your facility accredited by the appropriate accrediting organization? ☐ Yes ☐ No
13. Are all clients evaluated by a physician prior to receiving therapy? ☐ Yes ☐ No
    If not, explain: _____
14. Are all treatment plans and services performed kept in writing? ☐ Yes ☐ No
15. Is all equipment, electrical or otherwise, maintained and inspected regularly? ☐ Yes ☐ No
    If yes, are maintenance records kept in writing? ☐ Yes ☐ No

16. Are you affiliated with an exercise gym that is open to the public? ☐ Yes ☐ No
17. Do you offer use of your exercise equipment to the general public? ☐ Yes ☐ No
18. Does your work involve swimming pools? ☐ Yes ☐ No
19. Does your work involve driver training? ☐ Yes ☐ No
20. Do you sell vitamins or herbal supplements? ☐ Yes ☐ No
21. Do you offer holistic treatments or medicines? ☐ Yes ☐ No
22. Do you offer therapy involving animals? ☐ Yes ☐ No

*** If answered "Yes" to any of questions 16 through 22, provide details:** _____

23. Are consent forms signed prior to any treatment being performed? ☐ Yes ☐ No
24. If providing Occupational therapy, do you require physician's sign-off for client's return to work? ☐ Yes ☐ No
25. Check all procedures you use when hiring professional, paraprofessional, or any other employee who will provide patient care services at your facility:
    a. Educational background or residency program check, when applicable. ☐ None ☐ Verbal ☐ Written
    b. Previous employers check. ☐ None ☐ Verbal ☐ Written
    c. Police background check. ☐ None ☐ Verbal ☐ Written
    d. Drug screening. ☐ None ☐ Verbal ☐ Written
26. List any professional associations of which you are a member: _____
27. If only professional coverage is desired, name your general liability insurer, along with your policy number, policy limits, and the effective date:
28. Do you want your policy to cover your employees for their liability? (There is a charge.) ☐ Yes ☐ No
    NOTE: The policy already protects *you* for the acts of your employees.

If the insured is an Individual (not a Corporation), please answer questions 29 through 32.

29. Are you an employee of another person or organization? ☐ Yes ☐ No
    If yes, what is the name of your employer? _____
30. Do you have any management or supervisory responsibilities? ☐ Yes ☐ No
    If yes, describe: _____
31. If you contract your services to others on an independent contractor basis, for whom do you work? _____
32. Are you in private practice? ☐ Yes ☐ No

SEXUAL MOLESTATION COVERAGE: Sexual Molestation liability is offered for an additional premium charge.

If sexual molestation coverage is not desired, please check here ☐ Coverage is not requested.

33. Have you had any incidents or claims brought against you for sexual molestation or any other allegations of misconduct? ☐ Yes ☐ No
34. If you have employees, are there written guidelines in place regarding sexual misconduct? ☐ Yes ☐ No
    If **NO**, please explain: _____
35. Please check the limits you are requesting: ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000

_____ _____
Applicant's Signature Date

_____ _____
Title Producing Agent