CHUBB

The Trust Sponsored
Professional Liability Insurance Program

THE TRUST

Research or Academic Application Psychologists' Professional Liability

Insurance Company: ACE American Insurance Company
Administered by: Trust Risk Management Services, Inc.

CLAIMS-MADE/OCCURRENCE DISCLOSURE NOTICE
THE POLICY YOU ARE APPLYING FOR CONTAINS BOTH CLAIMS-MADE AND OCCURRENCE COVERAGES. PLEASE READ THE POLICY IN ITS ENTIRETY. SOME OF THE PROVISIONS CONTAINED IN THE POLICY RESTRICT COVERAGE, SPECIFY WHAT IS AND IS NOT COVERED AND DESIGNATE RIGHTS AND DUTIES.

Applying online at **www.trustinsurance.com** will expedite the approval and delivery of your policy.
You may complete the application below if you do not have Internet access.
A. Please type or print clearly in black ink.
B. Answer ALL questions completely. If any question or part of a question does not apply, print "N/A" in space. LEAVE NO BLANKS.

A

Please complete this section: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.

Name: _____

Degree: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Daytime phone number: _____

FAX number: _____

E-mail address: _____

Date of birth: _____ Last four SSN: _____

License Number: _____

Research or Academic Institution: _____

I prefer to have policy and renewal materials sent to me via (select one):
❑ E-mail (fastest) ❑ US Postal Service

I request my insurance coverage become effective on: _____

(This date may not be earlier than the date the application is received by TRMS and not more than 90 days from the date of this application.)

Are you a member of APA? ❑ Yes ❑ No

(Please note that membership is not required to be eligible to apply.)

If Yes, APA member number: _____

Other Association Affinity: _____

* The policy will be sent to you via email, requiring systems that permit you to open and view Adobe Acrobat PDF. You may request a paper copy of your policy at any time. You have the right to withdraw your consent to receive your policy electronically at any time by providing notice to us, however, such withdrawn consent will not affect or change the legal effectiveness, validity or enforceability of any documents that were delivered electronically prior to the date you notified us of the withdrawal of your consent.

B

Select a Limit of Liability:

Standard Protection for Teaching or Research Only			Expanded Protection for Academicians with Clinical Duties required by the University or Academic Institution		
Each Incident	Annual Aggregate	Annual Premium	Each Incident	Annual Aggregate	Annual Premium
❑ $1,000,000	$3,000,000	$134	❑ $1,000,000	$3,000,000	$268
❑ $1,000,000	$1,000,000	$103	❑ $1,000,000	$1,000,000	$206
❑ $200,000	$600,000	$80	❑ $200,000	$600,000	$160
❑ $100,000	$300,000	$70	❑ $100,000	$300,000	$140

Please Note: *This application is for a Claims Made policy. The Limit of Liability in effect at the time a Claim is made will be the maximum amount available subject to the terms and conditions of the policy.*

C

Check all the specific types of services provided as a Researcher or Academician:

(If you do not believe that your practice fits into any of the following categories, please attach a brief written description of the services you provide.)

❑ Academic Advising ❑ Dissertation Committee ❑ Serve on University or Department Committees
❑ Consultation ❑ Research ❑ Student Evaluation and Examination
❑ Supervision ❑ Teaching

❑ Clinical Practice (If selected, please indicate the number of clinical hours per week.)

Number of clinical hours per week required solely as part of your academic responsibilities _____

Number of clinical hours per week in any other setting _____

❑ Other _____ (Please attach a brief written description of the services you provide.)

D

Please answer all of the following:

1. Have you had any Claims or are you aware of any circumstances that may result in a Claim arising out of your professional services *(including incidents or occurrences reported to your prior carrier)?*
   ❑ Yes ❑ No
2. Have you been sanctioned or are you currently under review by any professional ethics body, state licensing board or other regulatory body or ever had your license revoked or suspended?
   ❑ Yes ❑ No
3. Have you been investigated for any HIPAA Privacy Rule violation or Medicare or Medicaid payment violation or are you aware of any such violation that may result in an investigation or proceeding before the United States Department of Health and Human Services (HHS) or its designee, or any state?
   ❑ Yes ❑ No
4. Have you been declined, canceled or nonrenewed by an insurance company for similar insurance? *(MISSOURI APPLICANTS–DO NOT ANSWER.)*
   ❑ Yes ❑ No

   (If you answered "Yes" to questions 1 through 4, please provide more information on a separate sheet of your letterhead and provide ALL available documentation.)

E

Professional Liability Insurance:

1. Have you had Professional Liability Insurance *(excluding student coverage)* in the past 5 years?
   ❑ Yes ❑ No If "No," please skip to section F.
   If "Yes," please list the Named Insured as shown on your current *(or most recent)* insurance policy: _____
2. Was your previous coverage written in the name of your employer?
   ❑ Yes ❑ No If "Yes," please skip to section F.
3. Was this prior policy with the Trust?
   ❑ Yes ❑ No If "No," please provide carrier name: _____
4. Type of Policy: ❑ Claims Made ❑ Occurrence
   If "Claims Made," did you purchase an Extended Reporting Period or Tail?
   ❑ Yes ❑ No If "Yes," please include a copy of your Extended Reporting Period or Tail.
5. Please provide the following information related to your previous policy:

   Effective Date: _____ Expiration Date: _____

   Per Incident Limit: _____ Aggregate Limit: _____

Please submit a copy of your most recent Declarations page. If the policy was Claims Made, this must include your Prior Acts Date or Retroactive Date.

F

Please read, sign and date:

In order to enhance the stability of the Professional Liability Insurance Program, The Trust has formed a purchasing group located and domiciled in Illinois pursuant to legislation enacted by Congress known as the Federal Liability Risk Retention Act of 1986. Coverage will be provided to the purchasing group by ACE American Insurance Company. Once this application has been approved and the premium has been received, you will automatically become a member of the Psychologists Purchasing Group Association and obtain the insurance coverage afforded through the Purchasing Group policy on an annual term, by issuance to you of a copy of the Purchasing Group policy and/or a certificate of insurance. (This paragraph does not apply to New York Applicants.)

I understand that I am not covered by this insurance if I am any of the following: physician, surgeon, dentist, surgeon's/physician's assistant, perfusionist, electroneurodiagnostic technologist, or cytotechnologist. I understand that these professional occupations are excluded from coverage. I understand I am not covered as a proprietor, owner, partner, manager, superintendent or officer of any hospital, sanitarium, medical clinic, health maintenance organization, managed care facility or network. I understand that this insurance will not apply for any owners who have proprietor or financial interest in any residential/overnight facility except in the delivery of professional services. The insurance described herein is subject to all terms, conditions and exclusions of the policy.

This application is subject to the underwriter's approval. Your completion of this application and premium payment does not obligate the insurance company to issue you insurance coverage. Coverage will become effective following approval of your application and clearance of your premium.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN. IN THE EVENT COVERAGE IS CANCELED AFTER IT IS BOUND, THE COMPANY WILL PROVIDE NOTICE OF SUCH CANCELLATION IN ACCORDANCE WITH APPLICABLE MARYLAND LAW.

IF THE COMPANY DISCOVERS A MATERIAL RISK FACTOR WITHIN FORTY-FIVE DAYS OF THE EFFECTIVE DATE OF COVERAGE OF A BINDER OR POLICY, OTHER THAN A RENEWAL POLICY, THE COMPANY SHALL RECALCULATE THE PREMIUM BASED ON THIS FACTOR, AS LONG AS THE RISK CONTINUES TO MEET THE COMPANY'S UNDERWRITING STANDARDS. THE COMPANY SHALL PROVIDE WRITTEN NOTICE TO THE INSURED OF THE REASON FOR AND AMOUNT OF THE PREMIUM RECALCULATION.

The applicant declares the information contained in the application and any attachments hereto is/are true and complete and that no material facts have been concealed, suppressed, misstated or misrepresented. In the event coverage is canceled after it is bound, the company will provide notice of such cancellation in accord with applicable Maryland law. If the company discovers a material risk factor within forty-five days of the effective date of coverage of a binder or policy, other than a renewal policy, the company shall recalculate the premium based on this factor, as long as the risk continues to meet the company's underwriting standards. The company shall provide written notice to the insured of the reason for and amount of the premium recalculation.

I agree to abide by the ethical standards of the American Psychological Association, including those standards relating to sexual intimacies with clients, dual relationships with clients and consultation with other psychologists/professionals.

I understand that the insurance applied for provides coverage for covered claims; for Occurrence applicants: as a result of acts that occur while the policy is in force; for Claims Made applicants: that are first made and reported to the company during the policy period for acts that occur after the policy's retroactive date and prior to the expiration date of the policy.

The undersigned acknowledges and agrees that information contained in this application, as well as subsequent information released in the underwriting or claim settlement process may be shared with the Trust for the purpose of their advocating on your behalf or development of risk management materials. For purposes of risk management materials, individual confidentiality will be protected.

The applicant agrees if the insurance coverage applied for is written, that this application and any attachments are deemed attached to and incorporated into the policy.

SIGNATURE OF APPLICANT **X**_____ DATE **X** _____

(This must be signed by the individual applying for insurance. Signature stamps are not acceptable.)

Please return your completed application to:

Trust Risk Management Services, Inc.;
1791 Paysphere Circle
Chicago, IL 60674

For faster service apply online at www.trustinsurance.com. If replacing coverage, please return your application at least 30 days before your expiration date. Please type or print clearly. Answer ALL questions completely.

Underwritten by ACE American Insurance Company. Administered by Trust Risk Management Services, Inc. (Florida Producer Sheila LeBeau License #PO99941). The completion of this application or the tendering of premium does not bind coverage. The application is subject to the Company's Underwriting Rules.

If you have any questions, please call TRMS toll-free at 1-877-637-9700 or E-mail TRMS at info@trustrms.com. Fax 1-877-251-5111.

If you prefer to pay by credit card, we accept Visa, Mastercard, and If you prefer to pay by credit card, we accept Visa, Mastercard, Discover and American Express. Please provide credit card information in the space below if payment by credit card is desired.

❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

Name on Card: _____

Signature: _____

Card Number: _____

Exp Date (MM/YY): _____ Amount: _____

Credit Card Billing Address: ❑ Same as Address in Section A

_____

_____