TRAVELERS

HEALTHCARE PROFESSIONALS ADDITIONAL INFORMATION REQUEST

Answer each question on behalf of all entities seeking insurance coverage, unless specifically requested otherwise.

*NOTE – coverage is not offered for Medical Doctors, Nurse Practitioners, Physicians Assistants, or Dentists.

An Additional Information section is provided at the end of this document for any information that exceeds the space provided.

GENERAL INFORMATION

Proposed First Named Insured & Other Named Insured(s):		Today's Date:
Proposed Effective Date (*mm/dd/yyyy)*:	Proposed Expiration Date *(mm/dd/yyyy)*:	

EMT/NURSES/SOCIAL WORK/FOSTER CARE INFORMATION

POSITION HELD	*FULL-TIME*		*PART-TIME*		*VOLUNTEERS*	
	Employee Count	*Total Hours*	*Employee Count*	*Total Hours*	*Volunteer Count*	*Total Hours*
Firefighters including First Response not EMT Certified						
Firefighter w/EMT Certification						
EMT Only						
Social Workers/Case Workers/Foster Care						
Counselors						
Therapists						
Jail Nurses						
Nurses						
Other						

1. Describe any licenses held: _____

2. Describe the types of services offered and department employing each professional: _____

3. Describe any continuing education programs: _____

4. Has the insured or organization been involved in any claims, suits, or incidents arising out of counseling services? ..... ☐ Yes ☐ No
   If yes, furnish full details including the amount of settlements, judgments or reserves: _____

5. Has insurance been canceled, declined or non-renewed for any reason during the last 3 years or is cancellation or nonrenewal pending? ..... ☐ Yes ☐ No
   If yes, Name of Company: _____
   Reason: _____

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INSURANCE REQUIREMENTS INFORMATION

6. Do you require the contracted health care service providers or professionals providing services to your organization to carry their own professional liability insurance? ☐ Yes ☐ No
   Indicate the minimum professional liability limits required: $ _____
7. Are certificates of insurance obtained? ☐ Yes ☐ No
8. Are you named as an additional insured under the contracted professional's policy? ☐ Yes ☐ No

HIRING/SCREENING PROCEDURES INFORMATION

9. Indicate each of the procedures you use when hiring or contracting professionals to provide services for you:
   - ☐ Verify educational background
   - ☐ Verify license or certification status
   - ☐ Check previous employers for employment
   - ☐ Check personal references
   - ☐ Check for any pending license suspensions or revocations, or any pending disciplinary actions by others
   - ☐ Check criminal history, including finger prints: ☐ Local ☐ Federal
   - ☐ Require information regarding professional claims history that resulted from the performance of or failure to perform professional services.

     If previous claims, how does that impact your procedures for hiring? _____

10. Are each of the procedures documented? ☐ Yes ☐ No
    If no, explain: _____

EMT / FIRE DEPARTMENT / PARAMEDIC INFORMATION

11. Are mutual aid agreements in place with neighboring communities? ☐ Yes ☐ No
12. Is Entity responsible for transporting injured persons? ☐ Yes ☐ No
13. Are all volunteers fully trained and certified according to minimum state requirements? ☐ Yes ☐ No
14. Is a substance abuse testing program in place, including volunteers? ☐ Yes ☐ No
15. Does the fire department have an established policies and procedures manual? ☐ Yes ☐ No
    If yes, is disciplinary action taken when these procedures are violated? ☐ Yes ☐ No
16. Does the medical response team have established policies and procedures manual? ☐ Yes ☐ No
    If yes, is disciplinary action taken when these procedures are violated? ☐ Yes ☐ No
17. Are EMT's / Paramedics in contact with the hospital/doctors at all times when responding to a call? ☐ Yes ☐ No
18. Are response times monitored and problems investigated? ☐ Yes ☐ No
19. Are written records kept of all calls, with a description of treatment and patient delivery to the hospital for medical response? ☐ Yes ☐ No
    How long are the records kept? _____

NURSE/JAIL NURSE ADDITIONAL INFORMATION

20. Number of hours worked by all nurses in one day (24 hour period):
    Jail Nurses: _____
    Nurses Other: _____

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SOCIAL SERVICES INFORMATION

21. Indicate whether or not you provide each of the following services:

	# Full-Time	# Part-Time
Marriage and family counseling	☐ Yes ☐ No	☐ Yes ☐ No
General psychological counseling	☐ Yes ☐ No	☐ Yes ☐ No
Pastoral counseling	☐ Yes ☐ No	☐ Yes ☐ No
Suicide or crisis hotline	☐ Yes ☐ No	☐ Yes ☐ No
Substance abuse - detoxification	☐ Yes ☐ No	☐ Yes ☐ No
Substance abuse - no detoxification	☐ Yes ☐ No	☐ Yes ☐ No
Vocation rehabilitation	☐ Yes ☐ No	☐ Yes ☐ No
Adoption	☐ Yes ☐ No	☐ Yes ☐ No
Foster care placement	☐ Yes ☐ No	☐ Yes ☐ No
Alternative incarceration home	☐ Yes ☐ No	☐ Yes ☐ No
Home care, home nursing, or similar type operation Legal aid	☐ Yes ☐ No	☐ Yes ☐ No
Other, describe: _____	☐ Yes ☐ No	☐ Yes ☐ No

22. Does the insured provide any specialized counseling services in such areas as drug abuse, depression, stress management, etc?..... ☐ Yes ☐ No
If yes, explain: _____

23. Does the insured charge for counseling services?..... ☐ Yes ☐ No
If yes, explain: _____

24. Does the insured do any counseling of non-residents of the entity?..... ☐ Yes ☐ No
If yes, explain: _____

FRAUD STATEMENTS

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

LOUISIANA and MAINE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Refer to the Core Application for all Fraud Statements.

SIGNATURES

Authorized Representative Signature*: **X**	Authorized Representative Name - Printed	Date:
Producer Signature*: **X**	State Producer License No (required in FL):	Date:
Agency:	Agency Contact:	Agency Phone Number:

* If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative

☐ Electronic Signature and Acceptance – Producer

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ADDITIONAL INFORMATION

This area may be used to provide additional information to any question. Please reference the question number.

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