



# # 6 Add New Employee Application- GROUP Occurrence Coverage Professional Liability Insurance



Underwritten by:  
Philadelphia Indemnity Insurance Company  
Philadelphia Indemnity Insurance is rated A+ ("Superior") by AM Best and Co. and is  
a leader in providing quality professional liability coverage to the mental health field.

## SECTION 1:

### INSURED INFORMATION

Group/Entity Name: **Women, Children & Family Counseling Services PLLC** Policy #: **E85903**

Contact Name: \_\_\_\_\_ Number of years insured with CPH & Associates: \_\_\_\_\_

Check ONE Affiliation:  CAMFT  AAMFT  AMHCA  ACA  ASCA  CSWA  IAMFC  Non-Members

Applicant/New Employee Name: \_\_\_\_\_

## SECTION 2:

### EMPLOYMENT STATUS AND CATEGORY FOR APPLICANT/NEW EMPLOYEE

Choose employment status of new employee:

Owner/Partner/Principal  
 W-2 Employee—for all employed professionals  
 Independent Contractor (1099)  
 Volunteer

Choose rating category:

MFT  LPC/LCPC/Counselor  LMHC  Social Worker  Psychologist  BCBA  
 BCABA  Rehabilitation  Case Manager  LEP  School Psychologist  
 School Counselor  Limited Licensed Psychologist  EAP  Psych Assistant/Associate  
 Drug & Alcohol Counselor  Post Masters/Intern under supervision  Student/Trainee  
 EIA Supervisor  Paraprofessional\*\*\*  Other (please describe): \_\_\_\_\_

*\*\*\*Paraprofessionals must include a job description & resume.*

## SECTION 3:

### QUALIFICATION QUESTIONS **\*\*If your answer to any of the questions is "Yes", please provide any pertaining documentation and a detailed explanation on a separate sheet.**

1. Have you <u>ever</u> had any of the following revoked, suspended, refused, canceled, declined for renewal, or voluntarily suspended?	A) Your State License or Certification B) Your Malpractice Insurance	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you <u>ever</u> had any claim or suit for alleged malpractice brought against you, or are you aware of any incident that might reasonably lead to a claim or suit?		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you <u>ever</u> been convicted of a misdemeanor or felony?		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Have you <u>ever</u> been reprimanded, disciplined, or had your license/certification/registration suspended or revoked by a court, Board of Examiners, licensing board, administrative or government agency, association, or ethics/peer review committee, or have you <u>ever</u> had any complaints filed against you with any such entity?		<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Do you have any issues that prevent you from complying with the ethical and professional standards set by any applicable licensing board, Association of which you are a member, Board of Examiners, regulatory board or peer review committee in all jurisdictions where you provide services?		<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you <u>ever</u> been accused of sexual misconduct or any impropriety?		<input type="checkbox"/> YES <input type="checkbox"/> NO

## SECTION 4:

### CHOOSE DESIRED EFFECTIVE DATE OF ADDITION, READ, SIGN AND DATE

**\*Please note coverage cannot be backdated, and endorsements will not be issued for coverage effective more than 75 days into the future.**  
 The applicant declares the information contained in the application is true and that no material facts have been suppressed or misstated. The applicant understands that incorrect information could void the insurance coverage. The signing of this application does not bind the undersigned to purchase this insurance, nor does the review of the application bind the insurance company to issue a policy. It is agreed that this application shall be the basis of the contract should a policy be issued. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act.

Signature of Name Insured: \_\_\_\_\_ Signature of Group Principal: \_\_\_\_\_

Desired Effective Date of Coverage: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please check ONE method for delivery of documents:  E-mail  Fax  Mail

E-mail address: \_\_\_\_\_ Fax #: \_\_\_\_\_

**NOTE: All requests are processed within 5-7 business days.**

Return completed application to: <b>CPH &amp; Associates 711 S. Dearborn, Suite 205 Chicago, IL 60605</b>	OR Fax to: 312-987-0902  <i>*If faxing, call during business hours, within 5 minutes after faxing, to confirm receipt: 312-987-9823 or 800-875-1911</i>	Business Hours (all hours listed are U.S. Central Time):  Monday & Friday: 8:30 am – 5 pm Tuesday – Thursday: 8:30 am – 9 pm Saturday: 10 am – 5 pm
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**CONFIDENTIAL**

**Background Check Authorization**

Print Name: \_\_\_\_\_  
(First) (Middle) (Last)

Former Name(s) and Dates Used: \_\_\_\_\_

Current Address Since: \_\_\_\_\_  
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: \_\_\_\_\_  
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: \_\_\_\_\_  
(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Drivers License Number/State: \_\_\_\_\_

The information contained in this application is correct to the best of my knowledge.

I hereby authorize \_\_\_\_\_ and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to \_\_\_\_\_ or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. \_\_\_\_\_ and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice to California, Minnesota and Oklahoma Residents:**

Please check the box below if you wish to receive a copy of a consumer report that is requested.

I wish to receive a copy of any Background Check Report on me that is requested.