TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

MEDICAL FACILITIES OUTPATIENT COUNSELORS / COUNSELING SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

1. Applicant Name:

2. Are you in a private practice? ☐Yes ☐No

Please indicate the (%) percent of time spent in the following work locations:

Location	%	Location	%	Location	%
Administrative Office		Patient's Home		Professional Office	
Classroom		Outpatient Clinic		Hospital (specify):	
Nursing Home		Jail/Prison		Other (specify):	

3. Indicate the (%) percent of total counseling:

Service	%	Service	%	Service	%
Family		Pastoral		Crisis Intervention	
Marital		Drug & Alcohol		Other (specify):	
Family Planning		Criminal			
Child/Youth		Domestic Abuse			

4. Please estimate the following:

Exposures	Next 12 Months	Last 12 Months
Number of outpatient visits		
Number of Counseling Calls		
Number of Hotline Calls		

5.

	Number of Full Time/ Part Time Employees	Number of Full Time/ Part Time Contractors
Administrators*		
Counselors*		
Psychologists		
Nurses, RN		
Nurses, LPN		
*Indicate Total with Masters Degree		
Home Health Aides		
Social Workers		
Clerical		
Teachers		
Physicians		
Minister/Priest/Rabbi		
Psychiatrists		

6. a. Do Independent Contractors carry their own professional liability that covers them while they are performing on behalf of you/your operations? ☐Yes ☐No

   b. Do employed Physicians/Psychiatrists carry their own professional liability that covers them while they are performing services on behalf of you/your operations? ☐Yes ☐No

7. List any Additional Insureds you request to be included and describe the relationship to you/your operations.

8. Please answer the following:

   a. Are you a religiously affiliated or pastoral counselor? ☐Yes ☐No ☐N/A
   If "N/A" skip to question 9

   If "Yes," number of families in church?_____

   b. Is there a charge for counseling services? ☐Yes ☐No

   c. Do you participate in any group activities? ☐Yes ☐No

   d. Do you participate in any overnight activities? ☐Yes ☐No

   If "Yes," please describe:

   e. Who supervises? _____

   f. How many supervisors? _____

   g. Do you participate in Day Care? ☐Yes ☐No

   If "Yes," please provide:

   the number of children: _____

   number of staff: _____

   hours of operation: _____

9. Is the Applicant engaged in, associated with, or involved in any other enterprise? ☐Yes ☐No

   If "Yes," please provide details:

10. List any professional associations in which the Applicant is a member :

11. Describe any professional training, licensing or certification needed for the Applicant's operation:

12.	Have there been any allegations of sexual abuse or misconduct brought against the Applicant or any of its employees? If "Yes," please explain:	☐Yes ☐No
13.	Does anyone applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? If "Yes," please explain:	☐Yes ☐No
14.	Does anyone applying for insurance under this policy use any form of recovered or repressed memory therapy? If "Yes," please explain:	☐Yes ☐No
15.	Does anyone applying for insurance under this policy testify or consult in child abuse proceedings (civil or criminal)? If "Yes," what percent of your time is devoted to this? _____ %	☐Yes ☐No
16.	Does the Applicant:	
	a. Prescribe medications? If "Yes," please explain:	☐Yes ☐No
	b. Provide Methadone or Suboxone Treatment? If "Yes," please provide protocols in place for administration of this medication.	☐Yes ☐No
	c. Administer Methadone or Suboxone onsite or prescribe for at home use?	☐ Onsite ☐ At Home ☐ Both
	d. Test for all of the following prior to administering Methadone or Suboxone: Benzodiazepines, Narcotics, Alcohol, Presence of Methadone or Suboxone If "No," please explain:	☐Yes ☐No
17.	If you contract your services to others on an independent contractor basis, advise who you contract your work to.	

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	