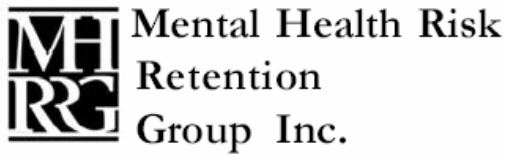


c/o Negley Associates

103 Eisenhower Parkway, Suite 101, Roseland, NJ 07068
1-800-845-1209 • (973) 830-8500 • Fax: (973) 830-8585
www.mhrrg.com

Professional & General Liability Insurance Application



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APPLICATION FOR PROFESSIONAL AND GENERAL LIABILITY COVERAGE

For this application to be processed in a timely fashion, please answer every question completely. If a question is not applicable, please write N/A. Do not leave any space blank.

1. Name of Insured _____

2. Mailing Address:

Street _____ County _____

City _____ Phone # _____

State _____ Zip _____ Fax # _____

Website _____ Contact _____

3. Type of Organization:

Individual _____ Corporation, for profit _____

Partnership _____ Corporation, nonprofit _____

Trust _____ Limited Liability Company (LLC) _____

4. Describe the purpose of the organization (attach brochures)

5. If more than one Named Insured is listed above, please explain the ownership and operational relationships.

6. Number of years in operation _____

7. Has any license or accreditation ever been suspended, denied or revoked? _____

8. Of what professional association(s) is the Insured a member in good standing?

9. Projected annual operating budget \$ _____ Include current Audited Financial Statement.

10. Current Insurance:

Professional Liability

General Liability

Company _____

Company _____

Inception Date: _____ Expiration Date: _____

Inception Date: _____ Expiration Date: _____

Premium \$ _____

Premium \$ _____

Deductible \$ _____

Deductible \$ _____

Limit of Liability \$ _____

Limit of Liability \$ _____

Occurrence Form? _____ or Claims Made? _____

Occurrence Form? _____ or Claims Made? _____

If Claims Made form, Retroactive Date _____

If Claims Made form, Retroactive Date _____

11. Limits Requested: Professional Liability \$ _____ General Liability \$ _____

12. Has any company cancelled or declined to renew insurance? (Not applicable to Missouri applicants) If yes, please explain.

13. Have there been any claims or lawsuits in the last five years? Yes No

Date of Loss Amount Paid or Reserved Claimant's Name/Description of Claim (Attach separate sheet if necessary)

_____	_____	_____
_____	_____	_____
_____	_____	_____

14. Are there any circumstances known which may give rise to a claim or lawsuit? Yes No If yes, explain. (Attach separate sheet if necessary)

It is understood that with respect to Questions 13 & 14 above, any claim or action arising out of such facts, circumstances or situations is excluded from the proposed coverage.

15. Schedule of Employees:

Number of
Full Time Part Time Volunteer

Administrators	_____	_____	_____
Case Managers	_____	_____	_____
Clerical	_____	_____	_____
Counselors	_____	_____	_____
Homemakers/Aides	_____	_____	_____
Nurses (LPN)	_____	_____	_____
Nurses (RN)	_____	_____	_____
Nurse Practitioners	_____	_____	_____
Psychologists	_____	_____	_____
Physician Assistants	_____	_____	_____
Social Workers	_____	_____	_____
Students	_____	_____	_____
Others, please specify _____	_____	_____	_____

16. Schedule of Physician Staff (Employed, Contracted or Volunteer) if none, write "none" _____.

Name	Specialty	Board Certified	Board Eligible	Hours/Week Worked	Employed, Contracted or Volunteer (E, C or V)	Carries own Malpractice Insurance	
						Yes	No
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

17. Do you wish physicians to be covered under the Center's policy? Yes No (Not applicable to Pennsylvania applicants)

18. Are drugs or medication administered or prescribed? Yes No If yes, please explain.

19. Is electroshock therapy utilized? Yes No If yes, how many per year? _____

20. Schedule of Locations: (Attach separate sheet if necessary.)

Loc. #	Complete Address (including zip code)	Sq. Feet	Type of Services Provided
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

21. List of Additional Insureds: (If none, write "none" _____) (Attach separate sheet if necessary.)

Name and Address (including zip code)	Interest
_____	_____
_____	_____
_____	_____

22. Units of Service – Please indicate the number of units of each service rendered by the facility, where appropriate:

Licensed Bed Capacity:

Mental Health Inpatient	_____	Group Home	_____
Alcohol/Drug Inpatient	_____	Shelters	_____
Alcohol/Drug Detox	_____	Independent Living	_____
Halfway House	_____	Foster Care	_____
		Other, please specify	_____

Annual Outpatient or Client Visits:

Alcohol/Drug Rehab	_____	Counseling	_____
Mental Health	_____	Other, please specify	_____

Clients per Day:

Adult Day Care	_____	Day Treatment	_____
Child Day Care	_____	Sheltered Workshops	_____
Case Management	_____	Other, please specify	_____

Annual Calls:

Hotline	_____	Information	_____
Referral	_____	Other, please specify	_____

Annual Employee Assistance Programs (EAP) Contacts or Visits:

Assessments	_____	Counseling Visits	_____
Referrals	_____	No. of Companies under Contract	_____

Home Health Care Visits:

Nonprofessional Hours	_____	IV Therapy	_____
Professional Hours	_____	Other, please specify	_____

Miscellaneous:

Mentor Matches	_____	Annual Methadone doses	_____
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Attach an application supplement for Residential or Inpatient, Day Care, Pre-School, Headstart, Methadone/Buprenorphine, Foster Care/Adoption, Sheltered Workshops/Products, if applicable.

23. Are there any camps, adventure/wilderness, ropes courses, or any type of recreational programs? If yes, please provide descriptive material. _____

24. Are there any swimming or boating activities? If yes, please provide details. _____

Very Important — Please attach copies of all available descriptive materials and/or brochures on your operations.

This application does not bind you nor us to complete the insurance, but it is agreed this form will be the basis of the contract should a policy be issued. This form will be attached to and become a part of this policy.

ANY FRAUD WARNINGS CONTAINED IN THIS APPLICATION DO NOT APPLY TO NEBRASKA OR VERMONT APPLICANTS.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD WARNING (APPLICABLE IN COLORADO):

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FRAUD WARNING (APPLICABLE IN TENNESSEE AND WASHINGTON):

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.

FRAUD WARNING (APPLICABLE IN VIRGINIA):

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.

FRAUD WARNING (APPLICABLE IN THE STATE OF NEW YORK):

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Probation Program: The Mental Health Risk Retention Group has a probation program for the benefit of its insureds which it believes is unique in the behavioral healthcare liability insurance market. When in the judgment of management an insured has adverse loss experience sufficient to justify nonrenewal, the insured may be placed on probation for one year rather than being nonrenewed. As part of probation an insured may be required to pay a premium surcharge and/or participate in a loss prevention program at its expense. This probation program is more fully described in the Company's current confidential private offering memorandum available on the Company's website at www.MHRRG.com. By signing this application, the undersigned represents that he or she agrees to the terms of the probation program as described in the offering memorandum.

SIGNATURE: _____

(Must be signed by the Executive Director)

TITLE: _____

(Please print or type name)

DATE: _____

IOWA LICENSED AGENT: _____

(Applicable in Iowa Only)

PRODUCER: Will you make the surplus lines filing for this policy? ___Yes ___No

Your Surplus Lines License Number _____()