SUPPLEMENTAL MENTAL AND PHYSICAL HEALTH RELATED INDIVIDUALS AND AGENCIES INCLUDING COUNSELORS APPLICATION

1. Applicant’s Name: ____________________________________________________________

2. List full names of all individuals or partners and their interests.
   ____________________________________________________________
   ____________________________________________________________

3. Applicant’s Professional Specialty ____________________________________________

4. Is applicant in private practice? _______________ or an employee? _______________

5. Indicate the percent of time spent in the following work locations:
   _____ % Administrative Office   _____ % Laboratory
   _____ % Classroom   _____ % Patient’s Home
   _____ % Hospital (be specific)   _____ % Professional Office
   _____ % Operating Room
   _____ % Other (be specific)   _____ % Outpatient Clinic

6. Please check the type of service provided:
   _____ Aide or Assistant   _____ Nutrition – Diets
   _____ Audiology   _____ Private Counseling
   _____ Contact Lens Technician-Optician   _____ Psychology (Private Practice Only)
   _____ Dental Hygiene   _____ Social Work
   _____ External Prosthetic Device   _____ Swimming Instructor
   _____ Guidance   _____ Therapy (Occupational, Physical, Respiratory, Speech)
   _____ Home Health Care
   _____ Hospice   _____ Other (be specific)
   _____ Marriage
   _____ Minister, Rabbi, Priest
   _____ Non-Profit Counseling (be specific)
   Non-Profit Referral Only – Hotlines (be specific)

7. Indicate the number of:
   Receipts ______
   Outpatient Visits ______
   Individual Professional Employees ______
Payroll
Participants
Other (be specific)

8. List any professional association in which applicant is a member:

________________________________________________________________________

Describe any professional training, licensing or certification needed for this operation: __________
________________________________________________________________________

9. If you are an employee, please advise if you have any management or supervisory duties. ______

________________________________________________________________________

If so, what are they? ______________________________________________________________________

10. Do you administer any anesthesia? _____ Yes _____ No

11. If you contract your services to others on an independent contractor basis, please advise to whom you
contract your work? ______________________________________________________________________

________________________________________________________________________

COVERAGE IS NOT BINDING UNTIL APPROVED BY THE COMPANY.

Applicant’s Signature _________________________________________________________________

Date: _____________________________________________________________________________