



ROBERT A. SCHNEIDER AGENCY, INC.

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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,
_____ Home Health Care	Respiratory, Speech)
_____ 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	_____ (Number of visits per year)
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: _____