



APPLICATION FOR CHIROPRACTORS PROFESSIONAL LIABILITY POLICY

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All questions must be answered completely. If the answer to any question is NONE or NOT APPLICABLE, so state. The application and all supplemental forms must be signed and dated by the applicant. If your most recent policy is "claims made" and you desire to continue coverage back to your "retroactive date", proof of continuous claims made coverage must be submitted with this application. (The Declarations Page of your most recent policy is adequate.)

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS APPLICATION, AND NEXT TO EACH ITEM BELOW, PLACE AN "X" IF INCLUDED OR "N/A" IF NOT APPLICABLE:

- _____ Risk Management related education course credits. _____ Claims Supplement
- _____ Declarations Page From Your Current Policy (If Prior Acts Coverage is Requested)
- _____ Sample literature, advertising or other promotional literature for the practice.

I. GENERAL INFORMATION

| | | | |
|--|---------------------|-------------------------|--|
| Applicant: _____ | | Social Security # _____ | |
| Home Address: _____ | | City, State, Zip _____ | |
| County: _____ | Home Phone #: _____ | Date of Birth: _____ | |
| Name of Professional Corporation, Partnership: (Attach a copy of the letterhead) _____ | | | |
| | | | |
| Business Address: _____ | | City, State, Zip _____ | |
| County: _____ | Bus. Phone #: _____ | Fax #: _____ | |
| Tax I.D. #: _____ | | | |

II. SCOPE OF PRACTICE

Is your practice (check one):

- Sole Practitioner (1099)
- Employed Practitioner (W2) Employed By: _____
- Partnership* Name of: _____
- Corporation* Name of: _____
- If Partnership or Corporation, do you wish to have separate limits applied to the corporation name?
 YES NO (NOTE: If "Yes", an additional charge of 10 % would apply.)

Please complete the table below. Be sure to include the names and particulars on all practicing chiropractors in your practice. (including yourself, partners and any employees.)

| Chiropractors | Name | License # (Include State) | License Exp. Date | Date 1 st Licensed | Hours Per Week |
|---------------|------|------------------------------|----------------------|----------------------------------|-------------------|
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(NOTE: Use additional sheet of paper if needed).

Please complete the table below to include the number of full time or part time employed personnel that work within your practice, and verify that they are licensed/certified:

| Type | Check if Licensed or certified | Number of Hours per week | Type | Check if Licensed or Certified | Number of Hours per week |
|-----------------------------------|--------------------------------|--------------------------|---|--------------------------------|--------------------------|
| Nurse/Nurse Aide | | | Medical Office Assistant | | |
| Dietician/Nutritionist | | | Occupational Therapist | | |
| Chiropractic Assistant/Technician | | | Physicians Assistant | | |
| Acupuncturist | | | Physicist/Biologist | | |
| EEG/EKG Technician | | | Social Worker | | |
| Laboratory Supervisor | | | X-Ray Technician | | |
| Massage Therapist | | | Medical Doctor or Doctor of Osteopathic | | |
| Medical Technician | | | Physical Therapist | | |

Please check all procedures and modalities that make up your practice and indicate the approximate percentages of time spent performing those procedure/modalities.

(NOTE: Total should equal 100%)

- _____ % Pure Hands-on Subluxation (soft tissue)
- _____ % Non-Invasive Electro Myography (used only to measure temperature and determine if subluxation exists)
- _____ % X-Ray (Other than therapy)
- _____ % Cryotherapy, Whirlpool, Traction
- _____ % Reflex Testing
- _____ % Ultrasound
- _____ % Non-Wet Hot or Cold Packs (hydrocollator canvas filled with silicon gel for heat, plastic bag wrapped ice for cold)
- _____ % Wet Heat or Ice Packs (towels or gauze, soaked and wrung out then applied directly as a compress)
- _____ % Massage Therapy
- _____ % Ice Massage
- _____ % Electric Stimulation for Treatment of Subluxation Related Conditions (Low Voltage)
- _____ % Sports Chiropractic (including taping and adjustments only)
- _____ % Orthopedic Testing
- _____ % Neuromusculoskeletal (NMS) (used as a test point to assess a subluxation related conditions)
- _____ % Acupuncture –Verify if professionals who perform these services are licensed YES NO
- _____ % Galvanic Acupuncture
- _____ % Drawing Blood for Diagnosis and Analysis
- _____ % Colon Irrigation
- _____ % Diathermy
- _____ % Microwave
- _____ % Extremity Adjusting (adjusting beyond paraspinal)
- _____ % Diagnosis and Treatment of all Conditions, including casting and broken bones.
- _____ % Laboratory Work including hair analysis and urinalysis
- _____ % Invasive Electromyography (EMG)
- _____ % Homeopathy
- _____ % Iridology (diagnosis through the eye)
- _____ % X-Rays (therapy), MRI's, CT Scans, or EKG's, has to be conducted in the practice
- _____ % Manipulation Under Anesthesia
- _____ % Orthopedic Procedures
- _____ % Minor Surgery
- _____ % Breast Gynecological Exams
- _____ % Other (PLEASE DESCRIBE: _____)
- 100** % **TOTAL**

III. PRACTICE PROFILE:

1. Number of locations operated, supervised, controlled _____ (list all on separate sheet of paper)
2. Number of patients seen by the practice per week _____
3. Do you utilize independent contractors in your practice? Yes No
 - a. If YES, indicate area of practice or specialty _____
 - b. Do you wish to have such independent contractors named as additional insureds? Yes No
If Yes, have you verified that they carry Professional Liability Coverage with limits at least equal to those for which you are applying, via this application? Yes No
 - c. On a separate sheet of paper, provide the names of those independent contractors you want added.
4. Do you conduct manipulation under anesthesia or sedation? Yes No
 - a. If YES, is it conducted at a facility which is licensed or certified to perform anesthesia or sedation by the state in which the facility is located? Yes No
5. Do you recommend vitamins/herbs as a nutritional supplement on a regular basis? Yes No
 - a. If YES, do you use vitamins/herbs in your practice as means of therapy for patients? Yes No
7. Do you refer patients to other providers for diagnosis outside the realm of chiropractic services?
 Yes No If YES, type of services referred: _____
8. Do you practice or provide professional services under any capacity other than those for which you are licensed as a chiropractor? Yes No If YES, please describe: _____

IV. REQUESTED COVERAGE:

1. What type of coverage are you requesting? Claims Made Occurrence
2. What is the desired effective date of your coverage? _____
3. Is your current coverage Claims Made Occurrence Do not currently have coverage
4. If coverage is currently Claims Made, do you wish to purchase prior acts coverage Yes No
If YES, please indicate Retroactive Date and provide a copy of your current policy Declarations page as evidence of continuous claims made coverage. Retroactive Date _____
5. Requested Limit of liability (Please check One)

| | |
|---|---|
| <input type="checkbox"/> \$100,000 per incident / \$300,000 aggregate | <input type="checkbox"/> \$1,000,000 per incident / \$2,000,000 aggregate |
| <input type="checkbox"/> \$200,000 per incident / \$600,000 aggregate | <input type="checkbox"/> \$1,000,000 per incident / \$3,000,000 aggregate |
| <input type="checkbox"/> \$250,000 per incident / \$750,000 aggregate | <input type="checkbox"/> \$2,000,000 per incident / \$2,000,000 aggregate |
| <input type="checkbox"/> \$500,000 per incident / \$1,000,000 aggregate | <input type="checkbox"/> \$3,000,000 per incident / \$3,000,000 aggregate |
| <input type="checkbox"/> \$1,000,000 per incident / \$1,000,000 aggregate | |
6. Requested deductible (please check one)

| | | | |
|-------------------------------|----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$15,000 |
|-------------------------------|----------------------------------|-----------------------------------|-----------------------------------|
7. Do you have contracts with parties, whereby you are required to add them as additional insureds for professional liability coverage onto your policy? Yes No
If YES, please provide information on a separate sheet of paper including the name(s) of those affiliates and describe their relationship to you.
8. This coverage automatically provides you up to \$ 2,500 per disciplinary proceeding/\$ 5,000 aggregate defense protection, for you or your firm if you become subject to a civil investigation or formal disciplinary action by your licensing board. Do you wish to have this coverage deleted/excluded for a reduction in premium? Yes No

List professional liability carried for each of the past five years. If none, state NONE.

| Carrier and Policy Number | Limits of Liability | Deductible | Premium | Expiration Date | Claims Made | Occurrence |
|---------------------------|---------------------|------------|---------|-----------------|-------------|------------|
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V. RISK MANAGEMENT

- 1. Have you completed a continuing education course or other instructional seminar or course in the past 24 months relative to any of the following or related **risk management** topics: patient communication, informed consent, confidentiality of records, litigation and related issues? Yes No
- 2. Are patient files documented each visit? Yes No
- 3. Are patient records dictated or transcribed? Yes No
If Yes, do you review for accuracy and initial? Yes No
- 4. Does your practice include **written Patient Safety Policy/practice standards**? Yes No
- 5. Does your practice utilize **“Terms of Acceptance” forms**? Yes No
- 6. Do you use promotional literature or print advertising? Yes No
If Yes, please include sample copies with this application.

VI. PERSONAL/PROFESSIONAL PROFILE

- 1. Have you or any of your employees ever had their professional liability insurance cancelled, declined, non-renewed, or accepted only on special terms? Yes No (If YES, please explain on a separate sheet of paper.)
- 2. Have you or any of your employees ever had their chiropractic license suspended, revoked, voluntarily surrendered, or subject to investigation in any state? Yes No (If YES, please explain on a separate sheet of paper.)
- 3. Have you ever been convicted of a crime in any state or county? Yes No (If YES, please explain on a separate sheet of paper.)

VII. CLAIMS HISTORY

- 1. Has any Professional Liability claim or suit ever been made against you, your predecessors in business or against any past or present partners or employees? Yes No (If YES, please complete claims supplement attached, for each)
- 2. Are there any circumstances of which you are aware that may result in any professional liability claim or suit being made against you, your predecessors in business or against any past or present partners or employees? Yes No (If YES, please provide details on a separate sheet of paper. Use one sheet for each incident)

I HEREBY REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT MY ANSWERS AND STATEMENTS WILL BE THE BASIS FOR DETERMINING MY INSURABILITY AND PREMIUM FOR THE PROFESSIONAL LIABILITY INSURANCE BEING APPLIED FOR. I FURTHER UNDERSTAND THAT THE COMPLETION AND SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE.

ANY PERSON WHO KNOWINGLY OR WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Signature _____

Date _____

Name Printed _____

Title _____

Agent Signature _____

Date _____

Agent Name (Print or Type) _____

Agency _____