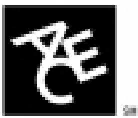

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APPLICATION FOR CHIROPRACTORS PROFESSIONAL LIABILITY POLICY

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 1st Licensed	Hours Per Week

(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 o certified	Number of Hours per week	Type	Check if Licensed o 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 exits)
_______ % X-Ray (Other than therapy)
_______ % Cryotherapy, Whirlpool, Traction
_______ % Reflex Testing
_______ % Ultrasound
_______ % Non-Wet Hot or Cold Packs (hydroclollatoral canvas filled with silicon gel for heat, plastic bag wrapped ice for cold)
_______ % Wet Heat or Ice Packs (towels or gauze, soaked and rung out then applied directly as a compress)
_______ % Massage Therap
_______ % Ice Massage
_______ % Electric Stimulation for Treatment of Subluxation Related Conditions (Low Voltage)
_______ % Sports Chiropractic (including taping and adjustments only)
_______ % Orthopedic Testing
_______ % Neuromusculoskeltal (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 Surger
_______ % 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 mea ns 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 you 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)
   ☐ $100,000 per incident / $300,000 aggregate
   ☐ $200,000 per incident / $600,000 aggregate
   ☐ $250,000 per incident / $750,000 aggregate
   ☐ $500,000 per incident / $1,000,000 aggregate
   ☐ $1,000,000 per incident / $1,000,000 aggregate
   ☐ $1,000,000 per incident / $2,000,000 aggregate
   ☐ $1,000,000 per incident / $3,000,000 aggregate
   ☐ $2,000,000 per incident / $2,000,000 aggregate
   ☐ $3,000,000 per incident / $3,000,000 aggregate
6. Requested deductible (please check one)
   ☐ None ☐ $5,000 ☐ $10,000 ☐ $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 automaticall 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 you 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 Numbe	Limits of Liabilit	Deductible	Premium	Expiration Date	Claims Made	Occu - rence

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 o 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** __________________________________