



(i) In \_\_\_\_\_ State  
 (ii) In \_\_\_\_\_ State  
 (iii) In \_\_\_\_\_ State  
 (iv) In \_\_\_\_\_ State

b. Please check one box describing your practice and fill in the blanks using an attached sheet, if necessary.

(i)  Sole proprietorship (unincorporated) \_\_\_\_\_  
 Business Name

(ii)  Professional corporation \_\_\_\_\_  
 Corporate Name

Do you want corporate coverage?  Yes  No

(iii)  Partnership \_\_\_\_\_  
 Partners' Names Partnership Names

(iv)  Employee, associate or independent contractor with \_\_\_\_\_  
 Employer's Name

c. Please tell us how many:

(i) Hours per week you practice chiropractic: \_\_\_\_\_

(ii) Patient visits you handle weekly: \_\_\_\_\_

d. Approximate gross annual income from your practice:

Less than \$50,000       \$100,000 to \$149,000       \$200,000 or more  
 \$50,000 to \$99,000       \$150,000 to \$199,999

e. Do you anticipate any changes in your practice in the next 12 months?  Yes  No  
 If Yes, please attach details.

**3. Procedures**

a. Please indicate those procedures or devices used in your practice:

	Yes	No		Yes	No
(i) General Meric adjusting			(xvii) Acupuncture		
(ii) Upper cervical specific			(xviii) Massages		
(iii) Instrumental adjusting			(xix) Short wave diathermy		
(iv) Gonstead/diversified			(xx) Kinesiology		
(v) Direct non-force			(xxi) Mechanical traction		
(vi) Sacro-occipital			(xxii) Whirlpool		
(vii) Hydroculator/heat packs			(xxiii) Stressology		
(viii) Electrical Stimulation			(xxiv) Gemstone therapy		
(ix) Ice-cryotherapy			(xxv) Toftness device		
(x) Trigger point			(xxvi) Colonic irrigations		
(xi) Cold laser			(xxvii) Treat cancer		
(xii) Activator			(xxviii) Treat epilepsy		
(xiii) Galvanic			(xxix) MUA		
(xiv) Ultraviolet			(xxx) Prenatal care & normal deliveries		
(xv) Ultrasound					
(xvi) Internal coccyx adjustment					

b. If the answer to any of the questions below is No, please attach details. Do you:

(i) Use the Georges test, the Vertebral Artery Ischemia Test or the Cerebrovascular Craniocervical Function Test when initially seeing a patient or when seeing a patient you have not seen for six months?  Yes  No

If No, please describe how you assess vascular flow: \_\_\_\_\_  
 Yes  No

If an unusual finding results, do you refer the patient to the appropriate medical practitioner?  Yes  No

- (ii) Make a differential diagnosis? 

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- (iii) Always record the patient's account of his/her progress? 

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- (iv) Always record objective findings? 

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- (v) Always record details of treatment procedures? 

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- c. If the answer to any of the questions below is YES, please attach details. Do you:
  - (i) Use acupuncture? 

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 If yes, do you use the National Council of Acupuncturists (NCCA) clean needle technique? 

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 Date Last NCCA exam taken and passed: \_\_\_\_\_  
 If No, do you use disposal needle? \_\_\_\_\_  
 If No, please attach details: \_\_\_\_\_
  - (ii) Dispense or prescribe: Drugs? 

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 Vitamins? 

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  - (iii) Use x-ray or imaging in treatment determination? 

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  - (iv) Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? 

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  - (v) Perform investigational or experimental research or therapy on human patients? 

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**4. APPLICANT OPERATIONS**

- a. (i) Do you use a collection agency: 

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 If Yes, please give name of agency: \_\_\_\_\_
- (ii) Has the agency authority to file a collectin suit at it's discretion? 

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- b. (i) Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? 

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- (ii) Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? 

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 If Yes, please attach details and submit copy of ALL advertisements.

**5. STAFF**

a. Please indicate the number of professional employees, volunteers and independent contractors. (If NONE, STATE NONE)

	No of Employees and Volunteers	No of Independent Contractors
(i) Chiropractor	_____	_____
(ii) Chiropractor Assistant	_____	_____
(iii) Nurses, Licensed Practical	_____	_____
(iv) Nurses, Practitioner	_____	_____
(v) Nurses, Registered	_____	_____
(vi) X-ray Technician	_____	_____
(vii) Laboratory Technician	_____	_____
(viii) Physical Therapist	_____	_____
(ix) Massage Therapist	_____	_____
(x) Student/Preceptors	_____	_____
(xi) Other: _____	_____	_____

NOTE: If you require any of the above to be Named Insureds, please submit a separate application for each individual.

- b. Are all the above individuals licensed in accordance with applicable state and federal regulations? If No, please attach explanation. 

<u>Yes</u>	<u>No</u>
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- c. Are you engaged in any business other than the practice of chiropractic? 

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 If Yes, please attach details.
- d. Do you own (wholly or in part), operate or administer any hospital, nursing home, surgi-center, clinic or other facility where healthcare services are customarily rendered? 

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If Yes, please attach details.

- e. Do you or the entity named in Question 2(b) contract to provide professional services to any individual, entity, or government entity?

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If Yes, please attach details.

- f. Are you affiliated with any hospitals?

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If Yes, please provide name(s), city, state

- g. Please list any professional societies/organizations in which you are currently a member:

**6. APPLICANT HISTORY/CLAIMS**

- |   | <u>Yes</u>               | <u>No</u>                |
|---|--------------------------|--------------------------|
| a. Have you or any of your employees: (Attach detailed explanation for any Yes answers)   |                          |                          |
| (i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a government or administrative agency, hospital or professional association? (Attach copy of Complaint and Consent Order documents, if applicable).                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required evaluation of an alleged mental condition and/or alcohol or drug addiction? | <input type="checkbox"/> | <input type="checkbox"/> |
| (iv) Ever had any state professional license refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (v) Ever had any professional liability insurance canceled, declined, renewal refused or accepted only on special terms?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (vi) Ever failed any professional licensing examination?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (vii) Any chronic physical illness or defect?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Has any claim or suit been brought against you and/or any of your employees?<br>If Yes, please complete a Supplemental Claim Form for each claim or suit.  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you aware of any circumstances which may result in a malpractice claim or suit against you or any of your employees?<br>If Yes, please complete a Supplemental Claim Form, giving details for each circumstances.  | <input type="checkbox"/> | <input type="checkbox"/> |

- d. Please list prior professional liability insurance for each of the past five years. If none, state none.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Exp. Mo/Day/Yr.	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form?	
							<u>Yes</u>	<u>No</u>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

- e. REQUESTED RETROACTIVE DATE: If prior professional liability insurance was on a claims made basis, advise the retroactive date of coverage: \_\_\_\_\_

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

I AUTHORIZE any professional society, prior or present insurer, business or professional associate, licensing board, governmental entity, corporation, partnership, organization, institution or person that may have any record or knowledge concerning any claim or any of the statements and answers made herein to release such information to the underwriting manager, Company and/or affiliates thereof. I authorize the use of a copy of this authorization in place of the original.

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*Printed Name of Applicant*

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*Title (Officer, Partner, etc.)*

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*Signature of Applicant*

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*Date*

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.



**Professional Liability Claims Information**

*(Must be printed or typed)*

Complete one form for each case. Copies may be made as needed.

Insurance Carrier: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Date of Occurrence: \_\_\_\_\_ Date of Suit: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Relationship to Patient (Treating Chiropractor, Consultant, etc.) \_\_\_\_\_

Primary Defendant: \_\_\_\_\_ Co-Defendant: \_\_\_\_\_

Patient Outcome: \_\_\_\_\_

Allegations made about care rendered: \_\_\_\_\_

Claim Status (Open, Closed, Pending): \_\_\_\_\_ Date: \_\_\_\_\_

If closed, indicate method of closing: (Circle below)

DISMISSAL                  SETTLED                  JUDGMENT                  CASE-DROPPED

Amount of settlement/judgment: \_\_\_\_\_ Date: \_\_\_\_\_

Chiropractor (print Name): \_\_\_\_\_ Date: \_\_\_\_\_

I understand that the information submitted here becomes a part of my insurance application and is subject to the same representations and conditions.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_