

- (iii) Always record the patient's account of his/her progress?[Yes [No
- (iv) Always record objective findings?.....[Yes [No
- (v) Always record details of treatment procedures?.....[Yes [No
- c. If the answer to any of the questions below is YES, please attach details. Do you:
 - (i) Use acupuncture?.....[Yes [No
 If Yes, do you use the National Council on Certification of Acupuncturists (NCCA)
 clean needle technique?.....[Yes [No
 Date last NCCA exam taken and passed. _____
 If No, do you use disposal needle?.....[Yes [No
 If No, please attach details.
 - (ii) Dispense or prescribe: Drugs?[Yes [No
 Vitamins?[Yes [No
 - (iii) Use x-ray or imaging in treatment determination?.....[Yes [No
 - (iv) Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic
 purposes, requiring the penetration of the skin?.....[Yes [No
 - (v) Perform investigational or experimental research or therapy on human patients?.....[Yes [No

4. APPLICANT OPERATIONS

- a. (i) Do you use a collection agency? [Yes [No
 If Yes, please give name of agency _____
- (ii) Has the agency authority to file a collection suit at its discretion? [Yes [No
- b. (i) Do you advertise your professional services in any manner (other than a simple listing in a telephone
 directory)? [Yes [No
- (ii) Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation
 of, patients? [Yes [No 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 separate application for each individual.

- b. Are all the above individuals licensed in accordance with applicable state and federal regulations?[Yes [No
 If No, please attach explanation.
- c. Are you engaged in any business other than the practice of chiropractic?[Yes [No
 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?[Yes [No

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 governmental entity? [] Yes [] No
If Yes, please attach details.

f. Are you affiliated with any hospitals? [] Yes [] No
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

- 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.) [] Yes [] No
 - (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [] Yes [] No
 - (iii) Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any has any administrative agency, hospital or professional association requested or required evaluation an alleged mental condition and/or alcohol or drug addiction? [] Yes [] No
 - (iv) Ever had any state professional license refused, suspended, revoked, renewal refusal or accepted only on special terms or ever voluntarily surrendered same? [] Yes [] No
 - (v) Ever had any professional liability insurance canceled, declined, renewal refused or accepted only on special terms? [] Yes [] No
 - (vi) Ever failed any professional licensing examination? [] Yes [] No
 - (vii) Any chronic physical illness or defect? [] Yes [] No
- b. Has any claim or suit been brought against you and/or any of your employees? [] Yes [] No
If Yes, please complete a Supplemental Claim Form for each claim or suit.
- c. Are you aware of any circumstances which may result in a malpractice claim or suit against you or any of your employees? [] Yes [] No
If Yes, please complete a Supplemental Claim Form, giving details for each circumstances.

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 Mo./Day/Yr.	Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?	
								Yes	No
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]

e. 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.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

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.