MEDICAL PROFESSIONAL LIABILITY –CHIROPRACTORS APPLICATION - (CLAIMS-MADE FORM)

All questions must be fully and completely answered. If there is not enough room in the space provided, a separate page(s) may be attached. Please mark "N/A" to any question that does not apply to your operation.

I. NAME OF APPLICANT: _____

Practice Address _____
Street City State Zip

Mailing Address (if different than above) _____
Street City State Zip

Is Practice Address your Residence? ☐ Yes ☐ No

Phone: ( ) -

II. Type of Practice:

☐ Individual ☐ Group Practice ☐ Partnership ☐ Professional Corp. ☐ Professional Assoc.

III. Number of Years in Practice: _____

Chiropractic College/Institution: _____ Graduated (Year) _____

Intern/Externship: From _____ to _____ Date Licensed: _____
mm/yy mm/yy

List any additional Degrees: _____

List any Associations/Memberships: _____

Are you an Athletic or Sport Team Practitioner? ☐ Yes ☐ No
If Yes, provide details by separate attachment.

Are you on Staff of any Hospital? ☐ Yes ☐ No
If Yes, provide details by separate attachment.

IV. ACTIVITIES AND SPECIALTY: please indicate by % your activities (total should equal 100%)

a. Chiropractor:
Class 1 – Hands on adjusting of vertebral subluxation only _____ %
Class 2 – Vertebral Subluxation (50% or more related to maintenance care) _____ %
Class 3 – Use of NMS test to evaluate symptoms; diagnosis/treatment of neuro-musculo-skeletal problems. _____ %
Class 4 – Diagnosis/Treatment of all conditions including casing of broken bones; Invasive bones; Invasive EMG; manipulations under anesthesia; minor surgery _____ %
(total = 100%)

b. List all States in which you are licensed to Practice Specialty described above.: _____

d. Have you or any of your employed or contracted staff been involved in any Disciplinary Action? ☐ Yes ☐ No

e. Have you or any other person for whom coverage is requested ever reported a potential claim or circumstance to a professional liability carrier? ☐ Yes ☐ No **If Yes, attach a statement giving full details.**

f. Are you aware of any claim, or act, error or omission which might reasonably be expected to result in a claim, against you? ☐ Yes ☐ No **If Yes, please attach statement giving full details.**

V. Number of outpatient visits: Present 12 months _____ Estimated for next 12 months _____

TOTAL GROSS REVENUE:	**Present 12 Months**	**Estimate for Next 12 months**

VI. Is the Applicant currently insured under a Commercial General Liability Policy? Yes ☐ No ☐
If Yes, please give details:

Insurance Company	**Type of Coverage**	**Limits BI**	**Limits PD**	**Effective From**	**Effective To**

VII. Is the Applicant currently insured under a Professional Liability Policy? Yes ☐ No ☐
If Yes:
Carrier:_____ Limits: _____occ/_____agg Claims Made ☐ Occurrence ☐
Deductible:_____ Retroactive Date:_____
Carrier _____ Limits _____occ/_____ Agg Claims Made ☐ Occurrence ☐
Deductible: _____

VIII. The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance. It is agreed that this application and the application on the current policy shall be the basis of the contract, and will be attached to the policy should a policy be issued.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

_____ _____ _____
Date **Signature of Applicant** **Title**