

## NATUROPATHIC PHYSICIAN PROFESSIONAL LIABILITY APPLICATION

(CLAIMS MADE POLICY FORM)

### NEW APPLICANTS - Please include:

- Your most recent malpractice policy declaration page
- 5 years loss history report from your most current malpractice carrier (report generated by your current/prior carrier showing any claim history)

### Please return completed application to:

[NaturalInsurance@SIGinsures.com](mailto:NaturalInsurance@SIGinsures.com) or  
 Fax to: 206-682-4993 or  
 Mail to: Sprague Israel Giles Insurance  
 1501 4<sup>th</sup> Avenue, Suite 730  
 Seattle, WA 98101-3225

### GENERAL INFORMATION - INDIVIDUAL PHYSICIAN INFO

1. Full name of naturopathic physician applying for coverage (you): \_\_\_\_\_
  
2. Full legal name of any business that you own (including DBA's) for which you are requesting coverage: \_\_\_\_\_  
 \_\_\_\_\_  
 Sole Proprietor ☐    Limited Liability Corp. ☐    Incorporated ☐    Other ☐ \_\_\_\_\_
3. Complete Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
4. Phone #: \_\_\_\_\_ Website address (if applicable): \_\_\_\_\_
5. Date of birth: \_\_\_\_\_
6. Name and Address of each clinic you practice at along with your interest in each location (check all that apply):  
 a. \_\_\_\_\_  
 Owner ☐ percent ownership \_\_\_\_\_ %    ||    Contract Worker ☐    ||    Employee ☐    ||    Tenant ☐    ||    Volunteer ☐  
 b. \_\_\_\_\_  
 Owner ☐ percent ownership \_\_\_\_\_ %    ||    Contract Worker ☐    ||    Employee ☐    ||    Tenant ☐    ||    Volunteer ☐  
 c. \_\_\_\_\_  
 Owner ☐ percent ownership \_\_\_\_\_ %    ||    Contract Worker ☐    ||    Employee ☐    ||    Tenant ☐    ||    Volunteer ☐
7. Are you the medical director supervising/instructing staff of a location you do not own?    Yes ☐    No ☐    If Yes, please explain: \_\_\_\_\_
  
8. If you own a clinic, please list the number of practitioners (not including yourself) and their designation (i.e. 2 ND's, 1 DC, etc.):  
 \_\_\_\_\_ Will all the practitioners carry malpractice?    Yes ☐    No ☐
9. Do you employ any physicians? (i.e. employees or independent contractors)    Yes ☐    No ☐ \* If Yes, complete Entity Information on pg. 3. \*  
 Are you seeking coverage for your work at all of the locations you will be practicing?    Yes ☐    No ☐    If no, attach explanation.
10. Will you be mentoring, supervising, training, teaching or proctoring students?    Yes ☐    No ☐  
 If yes, are students providing direct patient care?    Yes ☐    No ☐
11. State your estimated amounts of total revenue:  

Fee for Service or Salary	<u>Last 12 Months</u>	<u>Estimate for next 12 months</u>
	\$ _____	\$ _____
Do your product sales exceed \$250,000 per year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, state your sales \$ _____

### EDUCATION AND LICENSE INFORMATION

1. Name of institution where you received your naturopathic training: \_\_\_\_\_ Year/Month Graduated: \_\_\_\_\_
2. List all designations and associated services you wish to have covered: (i.e. ND, NMD, LAc, RPh) \_\_\_\_\_
3. ND License # \_\_\_\_\_ Year you began practicing Naturopathic Medicine: \_\_\_\_\_
4. List the states where you will practice: \_\_\_\_\_
5. Do you have a DEA license?    Yes ☐    No ☐    What is your DEA license number: \_\_\_\_\_  
 If yes, what schedule level? \_\_\_\_\_    If yes, what percentage of your patients do you prescribe to? \_\_\_\_\_ %

# SIG Naturopathic Physician Professional Liability Application

## PRACTICE INFORMATION

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
1. Basic Naturopathic Practice – Botanical Medicine, Homeopathy, Nutritional & Lifestyle Counseling, Chinese Herbal Medicine, Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	22. Lipodissolve If yes, # of patient encounters: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Naturopathic Manipulation • With general anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	23. Other Aesthetic Medicine Procedures Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	24. Other Laser Procedures Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Neural Therapy	<input type="checkbox"/>	<input type="checkbox"/>			
5. Chelation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	25. Platelet rich plasma therapy Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Prolotherapy	<input type="checkbox"/>	<input type="checkbox"/>	26. Do you do any stem cell therapy or injections? What type of stem cell treatments? _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Hormone Replacement Therapy	<input type="checkbox"/>	<input type="checkbox"/>	How are the stem cells collected? _____		
8. Bioidentical Hormone Replacement Therapy • Pellet Insertion	<input type="checkbox"/>	<input type="checkbox"/>			
9. Testosterone Injections	<input type="checkbox"/>	<input type="checkbox"/>	27. Sclerotherapy	<input type="checkbox"/>	<input type="checkbox"/>
10. Botox Injections In which parts of the body: _____	<input type="checkbox"/>	<input type="checkbox"/>	28. Will you inject into the spinal cord/column?	<input type="checkbox"/>	<input type="checkbox"/>
11. IV Therapy Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you perform mesotherapy? Do you inject a combination of Phosphatidylcholine (PC) & Dexoycholate (DC)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Pain Management Procedures Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	30. Will you practice tele-medicine or do house calls? If yes, name all types of tele-medicine: _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Surgery (other than minor) Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>			
14. Weight control (other than diet or exercise) Describe: _____ • HCG for weight control	<input type="checkbox"/>	<input type="checkbox"/>	31. If you practice tele-medicine, is all of it done with Patients of Record? If no, provide details: _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Will you be selling any products? What kind of products? _____ • Do you re-label these products in applicant's own name? • Identify any products you manufacture: _____ • Please list any products that you previously sold that are now banned substances or have been recalled: _____	<input type="checkbox"/>	<input type="checkbox"/>	32. Will you keep documented records on all patients?	<input type="checkbox"/>	<input type="checkbox"/>
16. Will you sell medical cannabis?	<input type="checkbox"/>	<input type="checkbox"/>	33. State the approximate division of patients ages: % under 13 _____ % 13-65 _____ % over 65 _____		
17. What % of your patients do you prescribe medical cannabis to? 10% or less _____ 11-25% _____ 26% or more _____			34. Will you be treating patients in a nursing home or long term rehabilitation center? • If yes, what percentage: _____ % • Describe services: _____ • Are you insured by the facility?	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you providing any obstetrical/midwifery services? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	35. Will you require a signed informed consent prior to treating all patients?	<input type="checkbox"/>	<input type="checkbox"/>
			36. Have you discontinued any services in the last 5 years? If yes, provide details: _____	<input type="checkbox"/>	<input type="checkbox"/>
19. Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	37. Other procedures not listed: _____	<input type="checkbox"/>	<input type="checkbox"/>
20. Laser Lipo (or similar)	<input type="checkbox"/>	<input type="checkbox"/>			
21. Laser Hair Removal	<input type="checkbox"/>	<input type="checkbox"/>			

## SIG Naturopathic Physician Professional Liability Application

### **PRIOR CARRIER INFORMATION**

Only needed if you are a new applicant and have been previously insured.

Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage:

**(If none, state NONE. If this is a renewal state RENEWAL).**

Carrier	Per Claim and Aggregate Limit	Deductible	Annual Premium	Retroactive Date	Policy Term Expiration (mm/dd/yy)
_____	_____	_____	_____	_____	_____

### **CLAIMS & DISCIPLINARY INFORMATION**

	YES	NO
A. Within the last <u>five years</u> has any claim been made against you for Medical Malpractice or a claim made under your General Liability policy? <u>If yes, please complete the Supplemental Claim Form on Page 4.</u>	<input type="checkbox"/>	<input type="checkbox"/>
B. Are you aware of any fact or circumstance which may give rise to a claim, or has any claim or suit for alleged malpractice been made against you that has not been reported to a prior insurer? <u>If yes, please complete the Supplemental Claim Information Form on Page 4 of this application.</u>	<input type="checkbox"/>	<input type="checkbox"/>
C. Have you ever been the subject of <u>any</u> investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency or professional association? <u>If yes, please attach explanation.</u>	<input type="checkbox"/>	<input type="checkbox"/>
D. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	<input type="checkbox"/>	<input type="checkbox"/>
E. Have you ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, or professional association requested or required applicant be evaluated for an alleged mental condition and/or alcohol or drug addiction? <u>If yes, please attach explanation.</u>	<input type="checkbox"/>	<input type="checkbox"/>
F. Have you ever had any state professional license refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? <u>If yes, please attach explanation.</u>	<input type="checkbox"/>	<input type="checkbox"/>
G. Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? <u>If yes, please attach explanation.</u>	<input type="checkbox"/>	<input type="checkbox"/>

### **ENTITY INFO**

Only needed if applicant owns a clinic, has employees, and/or has other practitioners providing patient care at your clinic.

Please provide the number of employees or independent contractors and whether or not they will carry their own individual medical malpractice coverage for their services on behalf of this entity:

	<u>Employees or</u> <u>Volunteers</u>	<u>Independent</u> <u>Contractors</u>	<u>Tenant or Lessee</u>	<u>Insured on their own</u> <u>Med Mal Policy?</u>	
				Yes	No
Naturopaths/Physicians	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Names of ND(s) _____					
Chiropractors	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Registered Nurses	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
LPN's or Nurse Aides	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapists	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Medical Assistants	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapists	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncturist	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

How did you hear about us? Colleague (Name: \_\_\_\_\_) ☐ Advertisement ☐ Online ☐ Conference ☐

I (applicant) declare 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 me as the applicant to purchase, this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations made in this application, **and this application will be made a part of the policy.** I understand that any subsequent contract issued by the Company will be issued on a claims-made form.

\_\_\_\_\_  
Print Full Name of Applicant

\_\_\_\_\_  
Email

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

This program is managed exclusively through Sprague Israel Giles, Inc.



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SUPPLEMENTAL CLAIM INFORMATION FORM  
(Complete one form for each claim)

1. Full name of applicant/Named Insured: \_\_\_\_\_
2. Name of other parties named in claim or defendants named in suit: \_\_\_\_\_  
\_\_\_\_\_
3. Date of alleged error or occurrence, or contact date: \_\_\_\_\_
4. Date claim was made: \_\_\_\_\_
5. Name of claimant: \_\_\_\_\_
6. Name of Insurance Company handling your claim: \_\_\_\_\_
7. Present status of claim or final disposition: \_\_\_\_\_  
\_\_\_\_\_

Is this Claim:                      Closed ☐                      Open ☐

8. Defense costs paid to date inclusive of any deductible: \_\_\_\_\_
9. If closed, total loss paid, inclusive of any deductible: \_\_\_\_\_
10. If claim is not closed, what are the insurer's reserves? Defense: \$ \_\_\_\_\_ Loss: \$ \_\_\_\_\_
11. Description of case and events including allegations and assessment of liability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Claimants last settlement demand: \_\_\_\_\_

\_\_\_\_\_  
Print Full Name of Applicant

\_\_\_\_\_  
Email

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date