

ENTITY COVERAGE
NATUROPATHIC PHYSICIAN
PROFESSIONAL LIABILITY APPLICATION
 (CLAIMS MADE POLICY FORM)

Please ensure all responses are legible and each question is answered completely.

1. Full name of applicant (name of registered business): _____

 (Include all DBAs and subsidiaries seeking coverage under this policy for which applicant is applying)

2. Complete mailing address: _____

3. List of all location addresses: _____

4. Website address: _____

5. Phone: _____

6. Date established: _____

7. Applicant is a:

- professional corporation joint venture limited liability company
 professional association partnership other _____

8. Name(s) of all partners or members of the business that have ownership interest and their professional designation (if applicable): _____

9. PRACTICE INFORMATION

A. Sources and amounts of total revenue:	<u>Last 12 Months</u>	<u>Estimate for next 12 months</u>
Fee for Service	\$ _____	\$ _____
Product Sales	\$ _____	\$ _____
Rental Income*	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____
Total Gross Revenue	\$ _____	\$ _____

* If you have rental income, please provide complete details: _____

B. State the approximate division of patients: % under 18 _____ % Age 18-65 _____ % Over 65 _____

C. Will the applicant require a signed informed consent prior to treating all patients: Yes No

D. Will the applicant keep documented records on all patients: Yes No

E. Please indicate the number of client encounters for each procedure below as performed under the Entity (applicant):

	Last 12 Months	Estimate for next 12 Months
1. Basic Naturopathic Practice (Botanical Medicine, Homeopath, Nutritional and Lifestyle Counseling)	_____	_____
2. Traditional Chinese Medicine	_____	_____
3. Naturopathic Manipulation	_____	_____
4. Minor Surgery - Please list procedures: _____	_____	_____
_____	_____	_____
5. Pain Management (Please list procedures: _____)	_____	_____
6. Chiropractic	_____	_____
7. Weight control (other than diet or exercise) Please describe: _____	_____	_____
_____ HCG Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
8. Acupuncture	_____	_____
9. Physical Therapy	_____	_____
10. Chelation Therapy	_____	_____
11. Prolotherapy	_____	_____
12. Sclerotherapy	_____	_____
13. Mesotherapy - Is Phosphatidylcholine (PC) or Deoxycholate (DC) used? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
14. Botox Injections - In which parts of the body: _____	_____	_____
15. Laser Treatments (non-surgical)	_____	_____
16. Laser Skin Treatments	_____	_____
17. Laser Hair Removal	_____	_____
18. Tattoo Removal	_____	_____
19. Lipoddisolve	_____	_____
20. Midwifery – Please describe: _____	_____	_____
21. Other Aesthetic Medicine Procedures - Please describe: _____	_____	_____
Other procedures not listed above _____	_____	_____
22. Total	_____	_____

F. Has the applicant discontinued any services in the last 5 years? Yes No
 If yes, provide details: _____

G. 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 Volunteers</u>	<u>Independent Contractors</u>	<u>Insured on their own Med Mal Policy</u>	
			Yes	No
Naturopaths/Physicians*	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Others	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

* For each naturopath or physician to be covered on this Entity coverage, attach a [separate Individual application](#). For all naturopaths and physicians who are covered under [separate policies](#), attach an insurance schedule (list) indicating names, professional designations, insurers, policy numbers, coverage limits and effective dates.

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- H. Will the applicant sell any products? (If yes, please answer the following:)
- a. What kind of products? _____ Yes No
- b. Will the applicant re-label any products in the business name? _____ Yes No
- c. Identify any products the applicant mixes or manufactures: _____
- d. Please list any products that the applicant previously sold that are now banned or recalled substances: _____
- e. Will the applicant sell medical marijuana? _____ Yes No
- f. Will anyone working for the applicant recommend or advise patients on medical marijuana? _____ Yes No

10. PRIOR CARRIER INFORMATION FOR THE ENTITY

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).

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

11. Is the applicant currently insured under a Commercial General Liability policy? _____ Yes No
 * If yes, please attach a declaration page.

12. CLAIMS & DISCIPLINARY INFORMATION

	YES	NO
A. Within the last five years has any claim been made against the applicant, any of its employees or contract workers for Medical Malpractice or a claim made under the applicant's General Liability policy? If yes, please complete the Supplemental Claim Form on Page 4 of this application	<input type="checkbox"/>	<input type="checkbox"/>
B. Is the applicant 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 the applicant, any of its employee or contract workers that has not been reported to a prior insurer? If yes, please complete the Supplemental Claim Information Form on Page 4 of this application.	<input type="checkbox"/>	<input type="checkbox"/>
C. Has the applicant, any of its employees or contract workers ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency or professional association?	<input type="checkbox"/>	<input type="checkbox"/>
D. Has the applicant, any of its employees or contract workers 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. Has the applicant, any of its employees or contract workers 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? If yes, please attach explanation.	<input type="checkbox"/>	<input type="checkbox"/>
F. Has the applicant, any of its employees or contract workers ever had any state professional license refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? If yes, please attach explanation.	<input type="checkbox"/>	<input type="checkbox"/>
G. Has the applicant, any of its employees or contract workers ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? If yes, please attach explanation.	<input type="checkbox"/>	<input type="checkbox"/>

I declare on behalf of the applicant 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 or 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.** The applicant understands that any subsequent contract issued by the Company will be issued on a claims-made form.

Print Name

Title

Signature of Applicant Owner/Partner/Member

Date

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SUPPLEMENTAL CLAIM INFORMATION FORM

(Complete one form for each claim)

- 1. 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