

**RENEWAL APPLICATION
ENTITY COVERAGE**

**PROFESSIONAL LIABILITY COVERAGE
(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 the policy for which applicant is reapplying)

2. Complete mailing address: _____

3. Website address: _____

4. Phone: _____

5. Has there been any material change in the business operation in the past 12 months (ie. New services provided, ownership change, change in location, new products being sold): Yes No

If yes, please describe: _____

6. **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 the applicant has rental income, please provide complete details: _____

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

C. 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>Independent</u>	<u>Insured on their own</u>	
	<u>Volunteers</u>	<u>Contractors</u>	<u>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 naturopathic doctor / physician to be covered (scheduled) on this Entity coverage, attach a **separate Individual application**. For all naturopathic doctors / physicians who are covered under **separate policies**, attach an insurance schedule indicating names, professional designations, insurers, policy numbers, coverage limits and effective dates.

SIG Naturopathic Physician Professional Liability Entity Application

D. 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: _____	_____	_____
22. Other procedures not listed above _____ Total	_____	_____
7. CLAIMS & DISCIPLINARY INFORMATION	YES	NO
A. Within the last year has any claim or suit been made against the applicant, any of its employees or contract workers for Medical Malpractice? If yes, please complete the Supplemental Claim Form on Page 4 of this application.	<input type="checkbox"/>	<input type="checkbox"/>
B. 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 in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
C. 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 in the past year?	<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"/>

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

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

Send completed application to: Sprague Israel Giles, Inc. 1501 4th Ave #2000 Seattle WA 98101-1637
Email nmed@sig-ins.com Voice 800.526.0635 Fax 206.682.4993



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