



INDIVIDUAL NATUROPATHIC PHYSICIAN COVERAGE

NATUROPATHIC PHYSICIAN
PROFESSIONAL LIABILITY APPLICATION
(CLAIMS MADE POLICY FORM)

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

Please attach the following documents to this application:

- Copies of your brochures, marketing or advertising materials
- Five years of currently valued company loss runs
- Information on disciplinary actions, licence revocations, etc.
- Copy of the most recent declarations page of your insurance

1. Full name of naturopathic physician applying for coverage (you): _____
 2. Name of any business that you own (including DBA): _____
Sole Proprietor Limited Liability Corp. Incorporated Other _____
 3. Your percent of ownership: _____% Does your business include any employees or independent contractors? Yes No
** If yes, please complete the Entity application. **
 4. Complete mailing address: _____
 5. Phone #: _____ Website address (if applicable): _____
 6. Name and Address of each clinic you practice at along with your interest in each one: (C/W = Contract Worker / Emp = Employee)
a. _____ Owner C/W Emp Tenant
b. _____ Owner C/W Emp Tenant
c. _____ Owner C/W Emp Tenant
 7. List the number of other practitioners and their designation (ie. 2 ND's, 1 DC, etc...) at each clinic: _____
_____ Do all the practitioners carry malpractice? Yes No
 8. EDUCATION AND LICENSE INFORMATION:
A. Name of Institution where applicant received your Naturopathic Training: _____
B. Designation Received: (ie. ND, NMD) _____ Years Attended: From: _____ To: _____
C. Year you began practicing Naturopathic Medicine: _____
D. List the states and license numbers where you practice: _____
(Please attach a copy of each active license)
 9. PRACTICE INFORMATION
A. State 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 will have rental income, please provide complete details: _____

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B. Please indicate the number of client encounters (not percentages) for each procedure below as performed by the 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	_____	_____

C. Have you discontinued any services in the last 5 years? Yes No
If yes, provide details: _____

D. Will you be selling any products? Yes No

a. What kind of products? _____

b. Do you re-label these products in applicant's own name? Yes No

c. Identify any products you manufacture: _____

d. Please list any products that you previously sold that are now banned substances or recalled: _____

e. Will you sell medical marijuana? Yes No

f. Will you recommend and/or advise on medical marijuana to patients? Yes No
If Yes, what percentage: _____ %

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

F. Will you require a signed informed consent prior to treating all patients: Yes No

G. Will you keep documented records on all patients: Yes No

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H. Will you practice tele-medicine? (ie. treatment by telephone, video, web conference, etc...) Yes No
 If Yes, name all types of tele-medicine you practice: _____
 If Yes, what percent of your practice is tele-medicine? _____ %

I. If you perform tele-medicine, is all of it done with Patients of Record? Yes No N/A
 If No, please provide details: _____

10. PRIOR CARRIER INFORMATION

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. 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? If yes, please complete the Supplemental Claim Form on Page 4.	<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? If yes, please complete the Supplemental Claim Information Form on Page 4 of this application.	<input type="checkbox"/>	<input type="checkbox"/>
C. Have you 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. 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? If yes, please attach explanation.	<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? If yes, please attach explanation.	<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? If yes, please attach explanation.	<input type="checkbox"/>	<input type="checkbox"/>

12. How did you hear about us? Colleague Advertisement Online Search Conference Other: _____

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.



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