

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA
2595 Interstate Drive, Suite 103, Harrisburg, PA 17110
ADMINISTRATIVE OFFICES: 175 Water Street, 18th Floor, New York, NY 10038
(A Capital Stock Insurance Company)

CHIROPRACTOR PROFESSIONAL LIABILITY PLUS APPLICATION

If CLAIMS MADE COVERAGE is chosen, READ THE FOLLOWING NOTICE:

NOTICE: COVERAGE IS LIMITED TO LIABILITY FOR CLAIMS FIRST MADE AGAINST YOU DURING THE POLICY PERIOD OR AN EXTENDED REPORTING PERIOD, IF APPLICABLE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE.

INSTRUCTIONS

- 1) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Applicable).
- 2) If you need more space for responses, continue on a separate sheet of paper and indicate question number.
- 3) The application must be signed and dated by the applicant.
- 4) If your most recent policy is "claims-made" and you desire to continue coverage back to your "retroactive date," proof of continuous claims-made coverage must be submitted with this application. (The Declarations Page of your most recent policy is adequate.)

I. INFORMATION

- 1) Applicant Full Name (including middle initial): Dr.
- 2) Referred By:
- 3) Type of Practice: (check one) Individual Independent Contractor with other doctors or Employee or Solo Practitioner-Unincorporated or Solo Practitioner-Incorporated or Professional Corporation with ownership
- 4) Primary Practice (Legal Name of Clinic you own or where you are employed):
(list additional locations on a separate sheet)
- 5) Owner of Clinic:
- 6) Primary Practice Address:
County: City: State: Zip:
- 7) Email Address: 8) Office Phone #:
- 9) Website: 10) Mobile Phone #:
- 11) Home Phone #: 12) Fax #:
- 13) Do you currently have Professional Liability Coverage? Yes No If yes, is it occurrence or claims made?
Claims-made Occurrence If claims made, retro date?
- 14) Requested Coverage: Professional Liability (check one) Claims-made Occurrence
- 15) Requested Effective Date:
- 16) Are you requesting your corporation or partnership entity (if applicable) be listed as a named insured and covered on a shared limit basis at no additional charge? Yes No
- 17) Are you requesting your corporation or partnership entity (if applicable) be listed as a named insured and covered on a separate limit basis at an additional charge? Yes No
- 18) Are you requesting an additional insured be added to your policy at an additional charge? Yes No
List the name: Relationship:

II. REQUESTED LIMITS (each incident/annual aggregate) (check one)

\$100,000/\$300,000 \$200,000/\$600,000 \$250,000/\$750,000 500,000/\$1,000,000 \$1,000,000/\$3,000,000

other:

Check (✓) here if you are an Indiana resident electing to participate in the Indiana Patient's Compensation Fund.
If so, your Limit of Liability will be \$250,000/\$750,000.

Check (✓) here if you are a Kansas resident required to participate in the Kansas Healthcare Stabilization Fund.
If so, your Limit of Liability will be \$200,000/\$600,000.

Check (✓) here if you are a Louisiana resident electing to participate in the Louisiana Patient's Compensation Fund.
If so, your Limit of Liability will be \$100,000/\$300,000.

Check (✓) here if you are a New Mexico resident electing to participate in the New Mexico Patient's Compensation Fund.
If so, your Limit of Liability will be \$200,000/\$600,000.

III. PRACTICE PROFILE

1. Number of patient visits each week:
2. Number of hours you work each week: (if 20 hours/week or less, complete the Part-Time Supplemental Application)

Please check if YOU perform any of the following procedures in your practice:

Exercise	
Nutritional supplements/counseling	
Electric Stimulation	
Diathermy	
Ultrasound	
Sports Chiropractic (treatment of injuries of high profile athletes or as a team doctor for organized amateur and professional sports teams)	
Lab work done directly by doctor (not referred out)	
Colon Irrigation	
Acupuncture	
Invasive EMG	
MRI, CT Scans, EKG done directly by doctor (not referred out)	
Hospital Privileges	
Manipulation under anesthesia (if checked, please complete the Manipulation Under Anesthesia (MUA) Application	
Minor Surgery	
Animal Adjusting (if checked, please complete the Professional Services to Animals (PSA) Supplemental Application	

IV. LICENSURE/EDUCATION

Chiropractic College Attended:

Graduation Date:

Chiropractor License Number(s)	State(s)	Date(s) first licensed

(list additional licenses on a separate sheet)

V. ADDITIONAL CHIROPRACTORS

(List all other chiropractors practicing in the same office with you and include all locations. Use separate sheet as needed.)

1. Name: Check (✓) here if currently insured
2. Name: Check (✓) here if currently insured

VI. RISK MANAGEMENT

- 1) Have you taken a continuing education patient safety or risk management course in the last two years? Yes No
- 2) Are patient progress documented each visit? Yes No
- 3) Your patient chiropractic record is: handwritten travel card dictated software: specify
- 4) If necessary, would you refer those patients who require additional clinical assessment, diagnosis and treatment outside the scope of Chiropractic? Yes No
- 5) Do you utilize informed consent forms? Yes No
- 6) Do you require signed release forms for the release of medical records? Yes No
- 7) Does your practice utilize written Patient Safety and Risk Management policies and procedures? Yes No
- 8) Are you an active (dues paying) member of a Chiropractic Association? Yes No (if yes, specify):

- 9) Have you ever been the subject of a Board Complaint, reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any employer, court or administrative agency or ever been the subject of any ethics investigation at local, state, or national level? Yes No ***If yes, please attach a separate sheet with full particulars. If an Administrative Hearing has ever been initiated against you, please complete and attach an Administrative Hearing Incident Form.***
- 10) Have you ever been denied, cancelled, refused renewal or accepted only on special terms for professional liability insurance coverage? Yes No ***If yes, please attach a separate sheet with full particulars. NOTE: MISSOURI RESIDENTS DO NOT RESPOND TO THIS STATEMENT***
- 11) Have you ever had your chiropractic license suspended, revoked, voluntarily surrendered, or been placed on probation in any state? Yes No ***If yes, please attach a separate sheet with full particulars.***
- 12) Have you ever been convicted of a crime in any state or country? Yes No ***If yes, please attach a separate sheet with full particulars.***

VII. CLAIM HISTORY

- 1) **LOSSES** Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss. **Complete our supplemental claims form for each loss/claim.**
- 2) **If you have no claims, initial here:**
- 3) Are you aware of any circumstance, accident or loss that has not yet been reported but which may result in a claim or suit being made against you, your predecessors in business or against any past or present partner(s)? Yes No ***If yes***, give dates, allegations and disposition of each claim or suit on our supplemental claims form for each loss/claim.

VIII. HISTORICAL PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please provide past policy information as requested. **List all Professional Liability policies** for each of the past five years. Begin with the current policies on the top line. **When referring to your prior coverage, please check either Claims Made or Occurrence.**

Policy Period	Insurer	Limits	Premium	Prior Policy Occurrence or claims made

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY

NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THE EARLIEST EFFECTIVE DATE FOR WHICH A POLICY MAY BE ISSUED IS THE DATE THIS APPLICATION IS RECEIVED IN OUR OFFICE.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY

MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Applicant's Signature: _____

Date: _____

Title: _____

Agent/Producer Name: _____

License #: _____

Signature of Agent/Producer: _____

Address: _____

Phone: _____ Fax: _____