



CHIRO
SECURE™



Chiropractic Professional Liability Insurance Application

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APPLICATION INSTRUCTIONS

1. Please fill out application completely
Print clearly
Answer ALL questions
If a question does not pertain to you, answer "N/A"
If you need to add any information, please attach a separate sheet of paper
2. Applications must be signed or will not be accepted.
3. Include the following attachments as part of your application:
Current Chiropractic License
Copy of office Letterhead
Current policy Declaration page
Certificate of attendance from any chiropractic seminar (Past 12 months)
4. Fax Application and ALL requested attachments to: **(480) 657-8505**

Our coverage is the only coverage that supports the ICA and is the original subluxation based program. I am confident that you will find that our coverage is still the one others are attempting to copy and is superior to most in the market.

We will continue to watch for the best coverage options to fit your needs. Please feel free to call me directly with any questions. My toll free Number is **(866) 802-4476 ext 11**.

Yours in Chiropractic,

Dr. Stuart E. Hoffman
President, ChiroSecure

NAME: _____
(First, Middle, Last)

If your current policy is "claims-made" and you desire to continue coverage back to your "retroactive date", proof of continuous claims made coverage (Current Policy Declarations Page) must be submitted with this application.

I. GENERAL INFORMATION

Home Address: _____ County: _____

City, State, Zip _____

Social Security # _____ Date of Birth: ____/____/____

Name of Professional Corporation, Partnership or DBA: _____

Contact Information: Home: (____) _____
Mobile: (____) _____
Office: (____) _____
Fax: (____) _____
E-mail: _____

Are you (check one):

- Sole Practitioner (1099)
- Employed Practitioner (W2) Employed By: _____
- Partnership
- Corporation

Primary Practice Address: _____ County: _____

City, State, Zip _____

Additional Locations: YES NO (If yes, attach separate sheet listing each location)

Chiropractic College: _____ Date of Graduation ____/____/____

Professional Association Memberships: (Please list all National & State memberships) _____

II. LICENSE INFORMATION

Date 1st Licensed ____/____/____ License # _____ State _____ Expiration ____/____/____

Number of Hours worked each week _____ Number of Patients seen per week _____

List ALL other chiropractors practicing in same office including all locations: (Use Separate sheet if needed)

NAME: _____

Date 1st Licensed ____/____/____ License # _____ State _____ Expiration ____/____/____

Number of Hours worked each week _____ Number of Patients seen per week _____

NAME: _____

Date 1st Licensed ____/____/____ License # _____ State _____ Expiration ____/____

Number of Hours worked each week _____ Number of Patients seen per week _____

II. LICENSE INFORMATION (CONTINUED)

(Additional)

NAME: _____

Date 1st Licensed ____/____/____ License # _____ State _____ Expiration ____/____

Number of Hours worked each week _____ Number of Patients seen per week _____

III. PRIOR INSURANCE COVERAGE

I have not had prior coverage in the past five years.

Reason: _____

List all previous carriers for the past five years. List the most recent first.

1. Insurance Company: _____ Policy # _____ Limits ____/____

CLAIMS MADE or OCCURRENCE Premium \$ _____ Expiration Date _____

2. Insurance Company: _____ Policy # _____ Limits ____/____

CLAIMS MADE or OCCURRENCE Premium \$ _____ Expiration Date _____

3. Insurance Company: _____ Policy # _____ Limits ____/____

CLAIMS MADE or OCCURRENCE Premium \$ _____ Expiration Date _____

IV. REQUESTED COVERAGE

Current Coverage:

- CLAIMS MADE Retroactive Date: *(Listed on Declaration page)* ____/____/____
 OCCURRENCE
 NONE

Type of Policy Requested: CLAIMS MADE OCCURRENCE

Desired effective date for coverage to begin? ____/____/____

Requested Limits: *(Limits shown are per claim/aggregate)**

\$100,000/ \$300,000 \$500,000/ \$1M

\$250,000/ \$750,000 \$1M/ \$3M

Please quote deductible option:

If Partnership or Corporation, would you like to purchase separate additional limits for the corporation?

(Note: Corporation is already covered with shared limits. Separate limits will have an additional 10% charge)

YES NO

Do you have contracts with parties such as an HMO that requires you to add them as additional insured's onto your policy? YES NO (If yes, please provide all pertinent information including name, address and relationship)

V. PRACTICE PROFILE

Do you utilize independent contractors in your practice? YES NO

If yes, what type of provider or specialties? _____

Do you wish to independent contractors named (for additional premium) as additional insured's? YES NO

If yes, please have you verified that they carry Professional Liability Coverage with limits at least equal to those for which you are applying, via this application? Yes No

Please provide the names and specialty of independent contractors you want added. (Use Separate sheet of paper)

Do you refer patients to other health care providers for diagnosis outside the realm of chiropractic services?

YES NO If yes, what types of providers would you refer to? _____

Do you provide any professional services under any capacity other than those for which you are licensed as a chiropractor? YES NO

If yes, describe: _____

Do you recommend vitamins/herbs as part of your practice? YES NO

If yes, do you recommend vitamins/herbs as specific therapy to treat medical conditions? YES NO

Do you employ other **licensed** persons to render professional services? YES NO

If yes, please enter the information in the table below:

Type	#	Hours/Wk	Type	#	Hours/Wk
Nurse/Nurse Aide	_____	_____	Medical Office Assistant	_____	_____
Dietician/Nutritionist	_____	_____	Occupational Therapist	_____	_____
<u>Certified</u> Chiropractic Assistant	_____	_____	Physicians Assistant	_____	_____
Acupuncturist	_____	_____	Physicist/Biologist	_____	_____
EEG/EKG Technician	_____	_____	Social Worker	_____	_____
Laboratory Supervisor	_____	_____	X-Ray Technician	_____	_____
Massage Therapist (Employee)	_____	_____	MD or DO	_____	_____
Massage Therapist (Indep Contractor)	_____	_____	Physical Therapist	_____	_____
Medical Technician	_____	_____			

VI. CLINICAL INFORMATION

Please check each of the following procedures performed by you or someone in your practice.

- | | |
|--|--|
| <input type="checkbox"/> Adjustment (Subluxation Correction) | <input type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Non-Invasive Para Spinal EMG |
| <input type="checkbox"/> Traction | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Ice/Heat | <input type="checkbox"/> Hair Analysis |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Orthopedic Testing |
| <input type="checkbox"/> Extremity Adjustment | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Diathermy | <input type="checkbox"/> Diagnosis/Treatment of Medical Conditions |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Other Procedures: _____ |
| <input type="checkbox"/> Sports Chiropractic | |

VI. CLINICAL INFORMATION (CONTINUED)

Do you do utilize any of the following procedures: No Yes

Reflex Testing, Ice Massage, Neuromusculoskeletal (NMS), Galvanic Acupuncture, Drawing Blood for Diagnosis and Analysis, Colon Irrigation, Diagnosis and Treatment of all Conditions including casting and broken bones, Invasive Electromyography (EMG), Homeopathy, Iridology, X-Ray Therapy, MRI's, CT Scans, or EKG's, Manipulation Under Anesthesia (If yes, please advise if it is conducted at a facility which is licensed or certified to perform anesthesia or sedation by the state in which the facility is located), Orthopedic Procedures, Minor Surgery, Breast Gynecological Exams

If so, please list and explain: _____

VII. RISK MANAGEMENT

Have you completed a continuing education seminar in the past 24 months relative to any of the following risk management topics: patient communication, informed consent, confidentiality of records, litigation and related issues? YES NO
(Must attach proof of attendance from any chiropractic seminar)

Are patient files documented each visit? YES NO

Are patient records dictated or transcribed? YES NO If yes, Do you review for accuracy? YES NO

Does your practice include written Patient/Office Policy? YES NO

Does your practice utilize "Informed Consent" forms? YES NO

Do you use promotional literature or print advertising? YES NO Type _____

VIII. PERSONAL PROFILE/CLAIMS HISTORY

Have you or any of your employees ever had their professional liability insurance cancelled, declined, non-renewed, or accepted only on special terms? YES NO (If yes, please explain on separate sheet)

Have you or any of your employees ever had their chiropractic license suspended, revoked, voluntarily surrendered, or subject to investigation in any state? YES NO (If yes, please explain on separate sheet)

Have you ever been convicted of a crime in any state or county? YES NO (If yes, please explain on separate sheet)

Has any Professional Liability claim or suit ever been made against you, your predecessors in business or against any past or present partners or employees? YES NO (If yes, please explain on separate sheet)

Are there any circumstances of which you are aware that may result in any professional liability claim or suit being made against you, your predecessors in business or against any past or present partners or employees?

YES NO (If yes, please explain on separate sheet)

I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that my answers and statements will be the basis for determining my insurability and premium for the professional liability insurance being applied for. I further understand that the completion and signing of this application does not bind the applicant or the insurance company to complete this insurance.

Any person who knowingly or with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime.

Name Printed _____

Title _____

Signature _____

Date _____