# 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
   *Current policy Declaration page (If you currently have an active claims made policy)
   *Certificate of attendance from any chiropractic seminar (Past 18 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

10135 E. VIA LINDA, SUITE D126 • SCOTTSDALE, AZ • 85258
PHONE: (480) 657-8500 • FAX: (480) 657-8505
WWW.CHIROSECURE.COM

# NAME: Dr. ______________________________________________

*(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 __________________________________________ Referred By: ________________

Social Security # ________________________________ Date of Birth: _______/_____/_________

**FULL Legal Name** of Professional Corporation, Partnership or DBA: ______________________________
Owner of Corporation ________________________________________________________________

Contact Information: Pleas list ALL

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

**Must be COMPLETE:**

**Your**
**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______________

## II. LICENSE INFORMATION (CONTINUED)

***(Additional)***

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 _______________

## III. PRIOR INSURANCE COVERAGE

**Current Coverage:**

☐ CLAIMS MADE **Retroactive Date:** (*Listed on Declaration page*) ______/____/________

☐ OCCURRENCE

☐ NONE

☐ 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 _________________

## IV. REQUESTED COVERAGE

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 and there must be at least 2 doctors in office*)
☐ 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 have independent contractors named *(for additional premium)* as additional insured's? ☐ YES ☐ NO
If yes, 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 | ______ | _______ |
| Certified 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.***

☐ Adjustment (Subluxation Correction)
☐ X-Ray
☐ Ice/Heat
☐ Electrical Stimulation
☐ Reflex Testing
☐ Extremity Adjustment
☐ Non-Invasive Para Spinal EMG
☐ Traction

☐ *Acupuncture
If yes, Do you do the Acupuncture? ☐Yes ☐No
What % of your time is spent doing Acupuncture? ____________

☐ Massage Therapy
☐ Ultrasound
☐ Hair Analysis
☐ Orthopedic Testing
☐ Sports Chiropractic
☐ Diathermy
☐ Urinalysis - % of your time spent ___________
☐ Diagnosis/Treatment of Medical Conditions
☐ Neuromusculoskeltal
☐ Other Procedures:

## VI. CLINICAL INFORMATION (CONTINUED)

Do you do utilize any of the following procedures in your office: No☐ Yes ☐

Ice Massage, 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-RayTherapy, 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 (1) chiropractic seminar*)

Does your practice include written Patient/Office Policy? ☐ YES ☐ NO
Does your practice utilize "Informed Consent" forms? ☐ YES ☐ NO
*Check www.chirosecure.com for sample*

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

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* ____________________________