



CHIRO  
**SECURE™**



*Chiropractic Professional Liability Insurance Application*

ace usa

**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 if available (Past 18 months)

**4. Fax Application and ALL requested attachments to: (480) 657-8505**

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**.

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

**NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA**

2704 Commerce Drive, Suite B

Harrisburg, PA 17110

**ADMINISTRATIVE OFFICES:** 70 Pine Street, New York, NY 10270

(A Capital Stock Insurance Company)

**CHIROPRACTORS PROFESSIONAL LIABILITY**

**APPLICATION**

All questions must be answered completely. If the answer to any question is NONE or NOT APPLICABLE, so state. The application and all supplemental forms must be signed and dated by the applicant. **If you requested prior acts coverage, proof of continuous claims-made coverage must be submitted with the application (the declaration page is adequate).**

**I. GENERAL INFORMATION**

- 1. Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
- 2. Primary office Address  Billing Address \_\_\_\_\_  
 No. and Street: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_  
 Office Fax No.: \_\_\_\_\_  
 E-mail: \_\_\_\_\_
- 3. Do you practice as:  Sole Practitioner  Partnership  
 Sole Practitioner (incorporated)  Professional Corporation  
 Employed Practitioner  Professional Association  
 Employee of: \_\_\_\_\_
- 4. Name of Professional Corporation, Partnership, Association: (Attach a copy of the letterhead) \_\_\_\_\_
- 5. How many hours per week are you treating, adjusting and consulting (including ime, utilization review and peer review)? \_\_\_\_\_
- 6. In chronological order, please list all states where you have practiced since graduation. (If more space is required, attach a separate sheet). Include current state and license number.

State	License Number	License Issue Date	Expiration Date

- 7. Are you a dues-paying member of a professional association?  Yes  No  
 If yes, please specify: \_\_\_\_\_

**II. EDUCATION AND TRAINING**

- 1. Undergraduate training: \_\_\_\_\_ Mo./Yr. Graduation \_\_\_\_\_  
 Major: \_\_\_\_\_
- 2. Chiropractic training: \_\_\_\_\_ Mo./Yr. Graduation \_\_\_\_\_
- 3. How many hours of continuing education have you completed in the last 24 months? \_\_\_\_\_
- 4. List any boards or organizations in which you hold certification or Diplomate status.  
 \_\_\_\_\_

**III. COVERAGE INFORMATION**

1. List professional liability carried for each of the past five years. If none, state NONE.

Carrier & Policy Number	Limits of Liability	Deductible	Premium	Expiration Date	Claims made	Occurrence

2. Please Check the coverage you are requesting:  Claims Made  Occurrence

A. Proposed Effective Date: \_\_\_\_\_  
 B. If your current coverage is claims-made, do you request Prior Acts Coverage?  Yes  No

Requested Retroactive Date: \_\_\_\_\_

**\*Please attach to this application a copy of your current policy Declaration Page(s) as evidence of continuous claims-made insurance coverage.**

**\*If Claims Made Coverage is chosen, please note the following:**

**NOTICE: COVERAGE IS LIMITED TO LIABILITY FOR CLAIMS FIRST MADE AGAINST YOU AND REPORTED IN WRITING TO US DURING THE POLICY PERIOD. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS POLICY COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.**

3. A. Requested Limits of Liability:  \$ 100,000 each incident / \$ 300,000 annual aggregate  
 \$ 200,000 each incident / \$ 600,000 annual aggregate  
 \$ 500,000 each incident / \$ 1,000,000 annual aggregate  
 \$1,000,000 each incident / \$ 1,000,000 annual aggregate  
 \$1,000,000 each incident / \$ 3,000,000 annual aggregate

B. Requested Deductible:  \$ 0  \$ 10,000  
 \$ 5,000  \$ 15,000

4. Corporate Entity Coverage: In addition to coverage for individuals, there is an option for adding additional coverage for your corporation. Please check the limit option you are requesting.

- Do not add this to my policy.
- Add this entity to my policy, with a single set of limits liability.
- Add an additional set of limits of liability to my policy for this entity for an additional premium.

5. Please provide on a separate attachment a list of any additional locations operated, supervised or controlled by you that you wish to list on your policy.

**IV. OPTIONAL COVERAGE – ADMINISTRATIVE HEARING COVERAGE**

1. An optional Limit of Liability of \$5,000 each Administrative Hearing / \$5,000 annual aggregate for Administrative Hearing Coverage is available. There is an annual premium of \$200 for this coverage.

Is coverage requested?  Yes  No

2. Have you ever been involved in any Administrative Hearings?  Yes  No  
 If yes, please provide on a separate attachment complete detail(s).

**V. UNDERWRITING PROFILE**

1. Has your professional liability insurance ever been canceled, declined, non-renewed, or accepted only on special terms? **NOTE: MISSOURI APPLICANTS DO NOT RESPOND.**  Yes  No  
 If yes, provide details: \_\_\_\_\_

2. Has your chiropractic license ever been suspended, revoked, voluntarily surrendered, or subject to probation in any state?  Yes  No  
 If yes, provide details: \_\_\_\_\_

3. Do you consult, teach or train outside your practice?  Yes  No  
If yes, provide details: \_\_\_\_\_
4. Have you ever been convicted of a crime in any state or country?  Yes  No  
If yes, provide details: \_\_\_\_\_
5. Have you ever been accused or engaged in behavior defined as sexual misconduct with any of your current or former patients or any current or former patients' spouse or any person with a direct relationship to the patient or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)?  Yes  No  
If yes, provide details: \_\_\_\_\_
6. Have you ever had any licensing board or professional ethics body ever require you to surrender your license or found you guilty of violations of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?  Yes  No  
If yes, provide details: \_\_\_\_\_

## VI. PRACTICE PROFILE

1. Number of patients seen per week: \_\_\_\_\_
2. Do you or the professional association, professional corporation or partnership have any employees?  Yes  No  
If yes, indicate the number in each category.
- |                                |       |  |       |
|--------------------------------|-------|--|-------|
| Chiropractors (other than you) | _____ | X-ray Technicians/Laboratory Technicians | _____ |
| M.D.'s or D.O.'s               | _____ | Receptionists, Chiropractic Assistants   | _____ |
| Nurses (RN, LPN, LVN)          | _____ | Physical Therapists                      | _____ |
| Independent Contractors        | _____ | Other _____                              |       |
- (describe)
3. Do you offer internships with a licensed chiropractor for pre or postceptors?  Yes  No  
If yes, attach a description of your training program curriculum and protocols.  
Number of internships annually: \_\_\_\_\_ Do you obtain proof of insurance?  Yes  No
4. Relating to chiropractic, do you perform outside peer reviews or Independent Medical Exams? \_\_\_\_\_  Yes  No
5. Do you refer patients to other health care providers for diagnoses outside the realm of chiropractic services?  Yes  No
6. Hospital affiliations?  Yes  No
7. Please check the Therapeutic Procedures and Modalities that you typically use in your practice: If you order tests, but the actual procedure is referred out, please identify by "RO".
- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> X-Ray                  | <input type="checkbox"/> TENS          | <input type="checkbox"/> Hair Analysis                          | <input type="checkbox"/> Iridology     |
| <input type="checkbox"/> Ultrasound             | <input type="checkbox"/> MENS          | <input type="checkbox"/> CT Scans                               | <input type="checkbox"/> Set Fractures |
| <input type="checkbox"/> Cryotherapy            | <input type="checkbox"/> Micro Current | <input type="checkbox"/> MUA                                    | <input type="checkbox"/> Vasectomies   |
| <input type="checkbox"/> Neurological Testing   |  | <input type="checkbox"/> Interferential                         | <input type="checkbox"/> EKG Screening |
| <input type="checkbox"/> Mechanical Traction    |  | <input type="checkbox"/> Galvanic                               | <input type="checkbox"/> Obstetrics    |
| <input type="checkbox"/> Acupressure            |  | <input type="checkbox"/> Acupuncture                            |  |
| <input type="checkbox"/> Hydrocollator          |  | <input type="checkbox"/> Hotwax                                 |  |
| <input type="checkbox"/> Vitamin Therapy        |  | <input type="checkbox"/> Venipuncture                           |  |
| <input type="checkbox"/> Homeopathic Supplement |  | <input type="checkbox"/> Urinalysis                             |  |
| <input type="checkbox"/> Orthopedic Testing     |  | <input type="checkbox"/> Infrared UV Light                      |  |
| <input type="checkbox"/> Whirlpool              |  | <input type="checkbox"/> Colon Irrigation                       |  |
| <input type="checkbox"/> Massage Therapy        |  | <input type="checkbox"/> Somatosensory Evoked Potential Testing |  |
| <input type="checkbox"/> Surface EMG            |  | <input type="checkbox"/> Pre/Post Natal Care                    |  |
8. Please list the adjusting techniques which are predominantly used in your practice: \_\_\_\_\_
9. Do you engage in any procedure, other than those above, requiring penetration of the skin?  Yes  No
- If you draw blood for diagnostic purposes, do you test for:
- |   |                                     |  |
|---|-------------------------------------|--|
| <input type="checkbox"/> Nutritional Deficiencies | <input type="checkbox"/> Infections | <input type="checkbox"/> Other (please describe) |
|---|-------------------------------------|--|

10. Do you provide consultations on weight management?  Yes  No  
 Do you dispense or prescribe:  
 1) any dietary regimen?  Yes  No  
 2) any type of dietary supplements?  Yes  No  
 3) other: \_\_\_\_\_  
 If yes to any of the above, please provide details on a separate sheet.
11. Are you, or is anyone in your practice, certified to practice acupuncture?  Yes  No  
 Please attach to the application a copy of each State license and Certification.
12. a) Do you own/lease (circle one) your x-ray unit?  Yes  No  
 b) Number of x-rays per month: \_\_\_\_\_  
 c) Date machine last calibrated: \_\_\_\_\_ Serviced by: \_\_\_\_\_  
 d) Do you use a certified Roentgenologist x-ray consultant?  Yes  No  
 e) How often are quality/safety checks performed on x-ray equipment? \_\_\_\_\_  
 f) Are logs maintained on all quality/safety checks?  Yes  No  
 g) How often do you x-ray patients? \_\_\_\_\_  
 h) Do you x-ray patients after treatment is completed?  Yes  No  
 i) Have you taken any post-graduate courses relating to x-ray studies?  Yes  No  
 j) For how long do you maintain copies of patient x-rays on file? \_\_\_\_\_
13. a) Do you have a site on the World Wide Web?  Yes  No  
 If yes, please provide address: \_\_\_\_\_  
 b) Do you provide chiropractic advice or services on the World Wide Web?  Yes  No  
 If yes, please provide details: \_\_\_\_\_
14. Do you use promotional literature? (Check all that apply)  ICA  ACA  PCRF  CM  
 Biological Arts  Other \_\_\_\_\_
15. Which advertising mediums do you use? (Check all that apply)  Newspaper  Radio  Television  
 Direct Mail  Yellow Pages  None  Other \_\_\_\_\_

1. Have you completed a Risk Management seminar in the last twelve (12) months?  Yes  No  
 If yes, please provide a copy of your certificate of completion for credit consideration.
2. Are patient files documented each visit?  Yes  No
3. Are patient records dictated and transcribed?  Yes  No  
 If yes, do you have in place a policy and procedure for weekly medical record reviews to ensure accuracy?  Yes  No
4. Do you enter into arbitration or similar agreements with your patients?  Yes  No
5. What is the average time that you spend professionally with each patient on his/her first office visit? \_\_\_\_\_

## VII. CLAIMS HISTORY

1. Has any professional liability claim or suit ever been made against you, your predecessors in business or against any past or present partner(s)?  Yes  No  
 If yes, please provide details on the claim supplement form attached. Use separate form for each claim.
2. 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 partner(s)?  Yes  No  
 If yes, please provide details on a separate sheet. Please use separate sheet for each incident.
3. Have any professional liability claims or suits been made or brought against any of your employees or any member, stockholder or partner of your professional association, professional corporation or partnership?  Yes  No  
 If yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The undersigned declare 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, and it will be attached to and become a part of the policy.

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.

**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 AND NEW MEXICO 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 IN THE THIRD DEGREE.

**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 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 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 AND VIRGINIA 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.

Principal's Signature \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

Submitting Agency: Arthur J. Gallagher Risk Management Services, Inc.

Signature of Agent: 

Or  
Submitting Agency: \_\_\_\_\_  
Signature of Agent: \_\_\_\_\_  
Date: \_\_\_\_\_

Arthur J. Gallagher Florida License Number: A014086  
Arthur J. Gallagher California License Number: OA13560

**Program Administrators**  
Arthur J. Gallagher Risk Management Services, Inc.  
6399 S. Fiddlers Green Circle, Suite #200,  
Greenwood Village, CO 80111-4949  
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