

New York - Application for Occurrence/Claims-Made Chiropractors Professional Liability Insurance

If you are a New York resident applying for Chiropractors Professional Liability on a Claims-Made basis, please note the following:

THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY.

This policy provides no coverage for claims arising out of dental incidents which take place prior to the retroactive date stated in this policy. This policy covers only claims actually made against the insured while the policy remains in effect and all coverage under this policy ceases upon termination, except for the automatic extended reporting period coverage, unless the insured purchases unlimited additional extended reporting period coverage. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates, and you can expect substantial annual premium increases, independent of overall rate level increases, until the claims-made relationship reaches maturity.



ace usa



ACE USA
Specialty Insurance

Application for Chiropractors Professional Liability Policy

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 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.)

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS APPLICATION, AND NEXT TO EACH ITEM BELOW, PLACE AN "X" IF INCLUDED, OR "N/A" IF NOT APPLICABLE:

_____ Continuing Education Course Certs. _____ Claims Supplement.
_____ Declaration Page From Your Current Policy (If Prior Acts Coverage Requested)

Applicant: _____		SS No.: _____	
Home Address: _____		City, State, Zip: _____	
County _____	Phone: _____	Date of Birth: _____	
Name of Professional Corporation, Partnership, Association: (Attach a copy of the letterhead) _____			
Business Address: _____		City, State, Zip: _____	
County _____	Phone: _____	Fax Number: _____	
Tax I.D. No.: _____			

1. In chronological order, please list all states where you have practiced since graduation. (If more space is required, attach a separate sheet).

STATE	LICENSE NUMBER	LICENSE ISSUE DATE	EXPIRATION DATE

2. Are you a dues-paying member of a professional association? Yes No

If yes, please specify: _____

3. Are you currently in active, full time practice? Yes No

If "no". Please describe your current practice on a separate sheet.

4. Please check the coverage you are requesting. CLAIMS MADE OCCURRENCE

REQUESTED COVERAGE

5. If your current coverage is claims-made, do you request Prior Acts Coverage? ____ Yes ____ No
 Requested Retroactive Date: _____
 Please provide a copy of your current policy Declaration Page(s) as evidence of continuous claims-made insurance coverage.
6. Proposed Effective Date: _____
7. (A) Requested Limits of Liability: (000's omitted) (B) Requested Deductible
- | | |
|---|-----------------------------------|
| <input type="checkbox"/> \$100 each incident / \$300 annual aggregate | <input type="checkbox"/> \$0 |
| <input type="checkbox"/> \$200 each incident / \$600 annual aggregate | <input type="checkbox"/> \$5,000 |
| <input type="checkbox"/> \$500 each incident / \$1,000 annual aggregate | <input type="checkbox"/> \$10,000 |
| <input type="checkbox"/> \$1,000 each incident / \$1,000 annual aggregate | <input type="checkbox"/> \$15,000 |
| <input type="checkbox"/> \$1,000 each incident / \$3,000 annual aggregate | |
8. Do you practice as:
- | | |
|---|---|
| <input type="checkbox"/> Sole Practitioner | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Sole Practitioner (incorporated) | <input type="checkbox"/> Professional Corporation |
| <input type="checkbox"/> Employed Practitioner | <input type="checkbox"/> Professional Association |
| <input type="checkbox"/> Employee of: _____ | |
9. Is coverage for your Corporation, Professional Association or Partnership being requested? ____ Yes ____ No
10. Number of locations operated, supervised or controlled _____ List Additional Locations on a separate sheet.

CURRENT COVERAGE

11. Is your current coverage: ____ Claims-made or ____ Occurrence
12. 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

UNDERWRITING PROFILE

13. Has your professional liability insurance ever been canceled, declined, non-renewed, or accepted only on special terms? NOTE: MISSOURI APPLICANTS DO NOT ANSWER. ____ Yes ____ No
 If yes, please explain (attach separate sheet if necessary): _____

14. Has your chiropractic license ever been suspended, revoked, voluntarily surrendered, or subject to probation in any state? ____ Yes ____ No
 If yes, please explain (attach separate sheet if necessary): _____

15. Do you consult, teach or train outside your practice? Yes No
 If yes, please explain (attach separate sheet if necessary): _____

16. Have you ever been convicted of a crime in any state or country? Yes No
 If yes, please explain (attach separate sheet if necessary): _____

17. 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, a blood relative of the patient or spouse or any person sharing the patient's domicile)? Yes No
 If yes, please explain (attach separate sheet if necessary): _____

18. 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, please explain (attach separate sheet if necessary): _____

PRACTICE PROFILE

19. Number of patients per week: _____
20. Give the names of ALL stockholders, partners or employees who are licensed to practice chiropractic. Attach a separate sheet if more space is needed.
21. Do you or the professional association, professional corporation or partnership have any employees?
 Yes No
 If yes, indicate the number in each category. (If none, so state.)
- | | | | |
|--------------------------------|-------|--|-------|
| 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 | _____ |
22. 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
23. a. Relating to chiropractic, do you perform outside peer reviews or Independent Medical Exams?
 Yes No
 If yes, percentage of practice time: _____
 If yes, provide details: _____

- b. Do you have a contract with an insurance company to do reviews? Yes No
 If yes, provide details: _____

c. Do you provide outside consulting? ____ Yes ____ No

If yes, provide details: _____

d. Do you serve on outside boards? ____ Yes ____ No

If yes, indicate boards you serve on: _____

24. Do you refer patients to other providers for diagnoses outside the realm of chiropractic services?

____ Yes ____ No

If yes, type of services referred _____

25. Are you affiliated with any hospitals? ____ Yes ____ No

If yes, please provide name(s) and address(es): _____

26. Please list the adjusting techniques which are predominantly used in your practice: _____

27. Please check the Therapeutic Procedures and Modalities that you typically use in your practice:

- | | | |
|---|---|---|
| <input type="checkbox"/> X-ray | <input type="checkbox"/> Acupressure | <input type="checkbox"/> Whirlpool |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Hydrocollator | <input type="checkbox"/> Cyrotherapy |
| <input type="checkbox"/> Pure Subluxation (Soft Tissue) | <input type="checkbox"/> Vitamin Therapy | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Mechanical Traction | <input type="checkbox"/> TENS | <input type="checkbox"/> MENS |
| <input type="checkbox"/> Homeopathic Supplement | <input type="checkbox"/> Neurologic Testing | <input type="checkbox"/> Surface EMG |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Venipuncture | <input type="checkbox"/> Hair Analysis |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Colon Irrigation |
| <input type="checkbox"/> MUA | <input type="checkbox"/> Infrared UV Light | <input type="checkbox"/> Hotwax |
| <input type="checkbox"/> Interferential | <input type="checkbox"/> Galvanic | <input type="checkbox"/> Micro Current |
| <input type="checkbox"/> Pre / Post Natal Care | <input type="checkbox"/> Orthopedic Testing | <input type="checkbox"/> CT Scans |
| <input type="checkbox"/> Somatosensory Evoked Potential Testing | <input type="checkbox"/> EKG Screening | <input type="checkbox"/> Vasectomies |
| <input type="checkbox"/> Set Fractures | <input type="checkbox"/> Full Prescription Rights | <input type="checkbox"/> Iridology |
| <input type="checkbox"/> Obstetrics | | |

28. a. Do you engage in any procedure, other than those above, requiring penetration of the skin?

____ Yes ____ No

If yes, explain: _____

b. If you draw blood for diagnostic purposes, do you test for?: ____ Nutritional deficiencies ____ Infections

____ Other (please describe): _____

29. Do you dispense or prescribe:

Any herbs? ____ Yes ____ No

Any vitamins? ____ Yes ____ No

Any dietary regimen? ____ Yes ____ No

Any nutritional supplements? ____ Yes ____ No

Any prescription drugs? * ____ Yes ____ No

*NOTE COVERAGE FOR ITEM(S) IS/ARE EXCLUDED

If yes to any of the above, attach a detailed explanation.

c. Do you provide outside consulting? ____ Yes ____ No

If yes, provide details: _____

d. Do you serve on outside boards? ____ Yes ____ No

If yes, indicate boards you serve on: _____

24. Do you refer patients to other providers for diagnoses outside the realm of chiropractic services?

____ Yes ____ No

If yes, type of services referred _____

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|---|---|---|
| <input type="checkbox"/> X-ray | <input type="checkbox"/> Acupressure | <input type="checkbox"/> Whirlpool |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Hydrocollator | <input type="checkbox"/> Cryotherapy |
| <input type="checkbox"/> Pure Subluxation (Soft Tissue) | <input type="checkbox"/> Vitamin Therapy | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Mechanical Traction | <input type="checkbox"/> TENS | <input type="checkbox"/> MENS |
| <input type="checkbox"/> Homeopathic Supplement | <input type="checkbox"/> Neurologic Testing | <input type="checkbox"/> Surface EMG |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Venipuncture | <input type="checkbox"/> Hair Analysis |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Colon Irrigation |
| <input type="checkbox"/> MUA | <input type="checkbox"/> Infrared UV Light | <input type="checkbox"/> Hotwax |
| <input type="checkbox"/> Interferential | <input type="checkbox"/> Galvanic | <input type="checkbox"/> Micro Current |
| <input type="checkbox"/> Pre / Post Natal Care | <input type="checkbox"/> Orthopedic Testing | <input type="checkbox"/> CT Scans |
| <input type="checkbox"/> Somatosensory Evoked Potential Testing | <input type="checkbox"/> EKG Screening | <input type="checkbox"/> Vasectomies |
| <input type="checkbox"/> Set Fractures | <input type="checkbox"/> Full Prescription Rights | <input type="checkbox"/> Iridology |
| <input type="checkbox"/> Obstetrics | | |

28. a. Do you engage in any procedure, other than those above, requiring penetration of the skin?

____ Yes ____ No

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b. If you draw blood for diagnostic purposes, do you test for?: ____ Nutritional deficiencies ____ Infections

____ Other (please describe): _____

29. Do you dispense or prescribe:

Any herbs? ____ Yes ____ No

Any vitamins? ____ Yes ____ No

Any dietary regimen? ____ Yes ____ No

Any nutritional supplements? ____ Yes ____ No

Any prescription drugs? * ____ Yes ____ No

*NOTE COVERAGE FOR ITEM(S) IS/ARE EXCLUDED

If yes to any of the above, attach a detailed explanation.

30. Are you, or anyone in your practice, certified to practice acupuncture? Yes No

Name of acupuncturist: _____

State License Number: _____

Attach a copy of State Certification

31. a. Do you own your own X-ray unit? Yes No

b. Number of X-rays per month: _____

c. License number of all X-ray Technicians: _____

d. Date machine last calibrated _____ Whom serviced by? _____

e. Do you use a certified Roentgenologist X-ray consultant? Yes No

f. How often do you X-ray patients? _____

g. Do you X-ray patients after treatment is completed? Yes No

h. Have you taken any post-graduate courses relating to X-ray? Yes No

i. Do you maintain copies of all X-rays on file? Yes No

RISK MANAGEMENT

32. Have you completed a Risk Management seminar in the last twelve (12) months? Yes No

If yes, provide a copy of your certificate of completion for credit consideration.

33. Are patients' files documented each visit? Yes No

34. Are your patient records dictated and transcribed? Yes No

If yes, do you review for accuracy and initial? Yes No

35. Do you enter into arbitration or similar agreements with your patients? Yes No

36. What is the average time that you spend professionally with each patient on his/her first visit? _____

Average time spent with each patient on follow-up visits? _____

37. Do you use a collection agency on late accounts? Yes No

38. Do you use promotional literature? Yes No

(Check all that apply)

ICA ACA PCRF CM Biological Arts Other _____

39. Which advertising medium do you use? (Check all that apply)

Newspaper Radio Television Direct Mail Yellow Pages None

EDUCATION AND QUALIFICATIONS

40. Chiropractic training completed at _____
(Name) (City) (State)

41. Graduation Date _____ Undergrad training completed at _____

Degree received Yes No Degree _____ Major _____

42. Continuing Education courses during the past five (5) years _____

43. List any board organizations in which you hold certificate or diplomate status _____

CLAIMS HISTORY

44. 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.

45. 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 one sheet for each incidence.

46. 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, provide details _____

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 THAT COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS.

SIGNING 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.

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 MATERIAL FACT THERETO, MAY BE GUILTY OF A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME. IN NEW YORK, ANY PERSON MAY ALSO BE SUBJECTED TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE FOR EACH VIOLATION.

Principal's signature: _____

Title: _____

Date: _____

Name of Agent: _____

Submitted by: _____

Address: _____
