

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)

NEW JERSEY CHIROPRACTOR PROFESSIONAL LIABILITY PLUS RENEWAL 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 ANY 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.

I. INFORMATION

Applicant Name: Dr. _____ Policy #: _____ Effective Date: _____

Retro Date: _____ Limits: _____

Legal Business Name of primary practice clinic _____
_____(list additional locations on a separate sheet)

Primary Practice Address: _____

City: _____ State: _____ Zip: _____

II. Please List Changes Since Last Application ("CHECK HERE IF" "N/A" (Not applicable).

Email Address: _____ Phone #: _____

Fax # _____ Website: _____

Legal Business Name of primary practice clinic: _____

- 1) Type of Practice: (check ☒ one) ☐ Individual Independent Contractor with other doctors ☐ Employee ☐ Solo Practitioner-Unincorporated ☐ Solo Practitioner-Incorporated ☐ Professional Corporation with ownership
- 2) Complete the following to extend coverage to an Entity/Corporation you own:
☐ N/A
☐ Shared Limits (**No Additional Charge**)
☐ Separate Limits (**Additional Charges Apply – Not available for a solo professional**)
- 3) Are you requesting an additional insured be added to your policy at an additional charge? ☐ Yes ☐ No
List the legal business name: _____ Relationship: _____

Primary Practice Address: _____

City: _____ State: _____ Zip: _____

Primary Mailing Address/Secondary Practice Address: _____

City: _____ State: _____ Zip: _____

Have you added any procedures, techniques, modalities or locations in the last year? (Please list)

Please list any other changes: (Including work hour changes)

III. Would you like to change your limits? (each incident/annual aggregate)

☐ Yes ☐ No

☐ \$100k/\$300k ☐ \$200k/\$600k ☐ \$250k/\$750k ☐ \$500k/\$1M ☐ \$1M/\$3M ☐ Other: _____

Please list reason for requested change: _____

REQUESTED DEDUCTIBLE: (check ✓ one):

☐ NONE ☐ \$5,000 ☐ \$10,000 ☐ \$15,000

IV. APPLICANT PROFILE

1) Number of **your** patient visits each week: _____

2) Number of hours per week with patients (must include your consulting, paperwork, and lab time related to patient care): _____ (if 20 hours/week or less complete the Part Time Supplemental Application)

3) Have you taken a continuing education patient safety or risk management course in the last two years? ☐ Yes ☐ No

4) Are you an active (dues paying) member of a Chiropractic Association? ☐ Yes ☐ No

1) (if yes, specify): _____

V. RISK MANAGEMENT

1) In the past year have you or (the corporation you own) been the subject of a Board Investigation, complaint, reprimand or disciplinary action? ☐ Yes ☐ No

If an Administrative Hearing has been initiated in the past year against you, please complete and attach an Administrative Hearing Incident Form (if you have not filled one out already).

2) In the past year have you had your chiropractic license suspended, revoked, voluntarily surrendered, or subject to probation in any state? ☐ Yes ☐ No

3) In the past year have you or (the corporation you own) reported any claims, notices or incidents to the company? ☐ Yes ☐ No

4) Are you aware of any circumstances, not yet reported, that may cause a claim to be made against you or (the corporation you own)? ☐ Yes ☐ No

5) In the past year have you been convicted of a crime in any state or country, or are you currently on trial pending adjudication for any criminal charges? ☐

Yes ☐ No

If you answered yes to any of the above questions, please attach a separate sheet with full particulars.

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 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.

Applicant's Signature: _____ Date: _____

Title: _____

Agent/Producer Name: _____ License #: _____

Signature of Agent/Producer: _____

Address: _____

Phone: _____ Fax: _____