# 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)

# STUDENT CHIROPRACTOR PROFESSIONAL LIABILITY APPLICATION

**MAINE**

This is an application for $1,000,000 chiropractic incident or occurrence / $3,000,000 aggregate combined Professional Liability and General Liability occurrence coverage.

**NOTICE: 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.

### INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED

**I. INFORMATION**

1. Applicant Full Name (including middle initial):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Primary Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

1. Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5) Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7) Applicant’s Chiropractic School Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8) Anticipated year to graduate from Chiropractic School:\_\_\_\_\_\_\_\_\_ 9) School website:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10) Requested Effective Date:

11) Where do you practice as a student/intern? □Solo practice □Group practice □Clinic □Hospital □ Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12) Name of Supervising Chiropractor (s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13) Address: County: City: State: Zip: \_\_\_\_\_\_\_

**II. CLAIM HISTORY**

1. Do you or your insured entity have any current or prior claims?                                                                         □ Yes  □ No               If yes, must submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss. Request and complete our supplemental claims form for each loss/claim.
2. Are you aware of any circumstance, accident or loss, including those arising from your billing practices that has not been reported to your insurance carrier but which may result in a claim or suit being made against you, your predecessors in business or against any past or present partner(s)?                                                                                         □ Yes  □ No               If yes, give dates, allegations and disposition of each claim or suit on our supplemental claims form for each loss/claim.
3. Have you ever been convicted of a crime in any state or country?                                                                □ Yes □ No                If you answered yes, please attach a separate sheet with full particulars.

**IMPORTANT NOTICE**

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. 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 MAINE 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.

Applicant’s Name:

Applicant’s Signature: Date:

Title:

Agent/Producer Name: License #:

Agent/Producer Signature: Date:

Address:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_