# 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)

# CHIROPRACTOR PROFESSIONAL LIABILITY PLUS APPLICATION

**NEW HAMPSHIRE**

**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 an 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.

4) 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.)

**I. INFORMATION**

1. Applicant Full Name (including middle initial): Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Type of Practice: (check ✓one) □ Individual Independent Contractor with other doctors □ Employee □ Solo Practitioner-Unincorporated □ Solo Practitioner-Incorporated □ Professional Corporation with ownership
2. (Legal Business Name of primary practice Clinic): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(list any additional locations on a separate sheet)

1. Owner of Clinic:
2. Primary Practice Address:

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

Secondary Practice Address (If applicable):

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

1. Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8) Office Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9) Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10) Mobile Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11) Home Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 12) Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13) Do you currently have Professional Liability Coverage? □ Yes □ No If yes, is it occurrence or claims made?

□ Claims-made □ OccurrenceIf claims made, retro date? \_\_\_\_\_\_\_

If no, please provide explanation:

14) Requested Coverage type of form: Professional Liability (check ✓one) □ Claims-made □ Occurrence

15) Requested Effective Date:

16) 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**)

17) Are you requesting an additional insured be added to your policy at an additional charge? □ Yes □ No

List the legal business name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. REQUESTED LIMITS** (each incident/annual aggregate)(check ✓one)

□$100k/$300k □$200k/$600k □$250k/$750k □$500k/$1M □$1M/$3M □other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. APPLICANT PROFILE**

1) Current or projected number of **your** patient visits each week: \_\_\_\_\_\_

2) List 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)

Please check if YOU or YOUR OFFICE performs any of the following procedures in your practice:

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  | Performed by You | If Checked, please indicate the estimated % of patient time you utilize this therapy |
| Acupuncture |  |  |
| Lab work  (done directly by you or staff you supervise in your office) |  |  |
| Colon Irrigation |  |  |
|  |  |  |
| Invasive/Needle EMG |  |  |
|  |  |  |
| Hospital Privileges – If current, please list hospital(s) |  |  |
| Manipulation under anesthesia (MUA) - (if coverage is needed, please complete the MUA Supplemental Application for Underwriting Consideration) |  |  |
| Minor Surgery |  |  |
| Animal Adjusting (if coverage is needed, please complete the Professional Services to Animals (PSA) Supplemental Application for Underwriting Consideration.) |  |  |

**IV. LICENSURE/EDUCATION**

Chiropractic College Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Graduation Date:\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Chiropractor License Number(s) | State(s) | Date(s) first licensed |
|  |  |  |
|  |  |  |
|  |  |  |

(list additional licenses on a separate sheet)

**V. ADDITIONAL CHIROPRACTORS**

(List all other chiropractors practicing in the same office with you and include all locations. Use separate sheet as needed.)

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check (✓) here□ if currently insured

2. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check (✓) here□ if currently insured

**VI. RISK MANAGEMENT**

1. Have you taken a continuing education patient safety or risk management course in the last two years? □ Yes □ No
2. Is patient progress documented each visit? □ Yes □ No
3. Your patient chiropractic record is: □ handwritten □ travel card □ dictated □ software: specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. If necessary, would you refer to other healthcare practitioners, those patients who require additional clinical assessment, diagnosis and treatment outside the scope of Chiropractic? □ Yes □ No
5. Do you utilize informed consent forms? □ Yes □ No
6. Do you require signed release forms for the release of medical records? □ Yes □ No
7. What resource(s) does your practice utilize regarding patient safety standards and office procedures , such as patient education materials, office manual, other??
8. Are you an active (dues paying) member of a Chiropractic Association? □ Yes □ No (if yes, specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Have you or (the corporation you own) ever been the subject of a Licensing Board investigation, complaint, reprimand or disciplinary action □ Yes □ No  ***If an Administrative Hearing has ever been initiated against you, please complete and attach an Administrative Hearing Incident Form.***
10. Have you ever had your chiropractic license suspended, revoked, voluntarily surrendered, or been placed on probation in any state?
11. Have you ever been denied, cancelled, refused renewal or accepted only on special terms for professional liability insurance coverage? (Please indicate even if already reported) □ Yes □ No **NOTE: MISSOURI RESIDENTS DO NOT RESPOND TO THIS STATEMENT**
12. Have you ever had your chiropractic license suspended, revoked, voluntarily surrendered, or been placed on probation in any state? □ Yes □ No
13. Have you ever been convicted of any crime, other than a minor traffic violation in any state or country? □ Yes □ No ***If you answered yes to any questions between 10-12, please attach a separate sheet with full particulars.***

**VII. 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.***

# VIII. HISTORICAL PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please provide past policy information as requested. **List all Professional Liability policies** for each of the past five years.

Begin with the current policies on the top line. *When referring to your prior coverage, please check either Claims Made* ***or*** *Occurrence.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Policy Period | Insurer | Limits | Premium | Prior Policy Occurrence or  claims made |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

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.

THE DISCOVERY OF ANY FRAUD OR MATERIAL MISREPRESENTATION AFFECTING THE POLICY WILL CAUSE THE POLICY TO BE CANCELLED IN ACCORDANCE WITH THE REQUIREMENTS OF RSA 417-C.

**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.

Applicant’s Signature: Date:

Title:

Agent/Producer Name: License #:

Signature of Agent/Producer:

Address:

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