



ACE American Insurance Company

# 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.)

## I. GENERAL APPLICANT INFORMATION

**Applicant Name: Dr.** \_\_\_\_\_

Primary Practice Address: \_\_\_\_\_ County: \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Referred By: \_\_\_\_\_

Home Address: \_\_\_\_\_ County: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FULL Legal Name** of Professional Corporation, Partnership or DBA: \_\_\_\_\_

Owner of Corporation \_\_\_\_\_

Contact Information: Please list ALL

Home: (\_\_\_\_) \_\_\_\_\_

Mobile: (\_\_\_\_) \_\_\_\_\_

Office: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

**Are you (check one):**

Sole Practitioner (1099)

Employed Practitioner (W2)

Partnership

Corporation

Employed By: \_\_\_\_\_

Additional Locations:  YES  NO (If yes, attach separate sheet listing each location)

## II. LICENSE, EDUCATION AND QUALIFICATIONS INFORMATION

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

STATE	LICENSE NUMBER	DATE FIRST LICENSED	EXPIRATION DATE

2. Chiropractic College: \_\_\_\_\_ Date of Graduation \_\_\_\_\_

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

4. Are you currently in active, full time practice?  Yes  No If "no", please briefly describe your current practice along with number of hours. \_\_\_\_\_

5. a. If in active full time practice, number of hours worked each week: \_\_\_\_\_ b. Number of patients seen per week: \_\_\_\_\_

6. **List ALL other chiropractors practicing in same office including all locations:** (Use separate sheet if needed.)

a. **NAME:** \_\_\_\_\_  
 Date 1<sup>st</sup> Licensed \_\_\_\_ / \_\_\_\_ / \_\_\_\_ License # \_\_\_\_\_ State \_\_\_\_\_ Expiration \_\_\_\_ / \_\_\_\_  
 Number of Hours worked each week \_\_\_\_\_ Number of Patients seen per week \_\_\_\_\_  
 Check if:  Owner  Partner  Employee  Independent Contractor  
 Currently Insured?  Yes  No Company \_\_\_\_\_ Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Limits \_\_\_\_ / \_\_\_\_  
 If not currently insured please explain reason: \_\_\_\_\_

b. **NAME:** \_\_\_\_\_  
 Date 1<sup>st</sup> Licensed \_\_\_\_ / \_\_\_\_ / \_\_\_\_ License # \_\_\_\_\_ State \_\_\_\_\_ Expiration \_\_\_\_ / \_\_\_\_  
 Number of Hours worked each week \_\_\_\_\_ Number of Patients seen per week \_\_\_\_\_  
 Check if:  Owner  Partner  Employee  Independent Contractor  
 Currently Insured?  Yes  No Company \_\_\_\_\_ Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Limits \_\_\_\_ / \_\_\_\_  
 If not currently insured please explain reason: \_\_\_\_\_

**III. CURRENT AND PRIOR INSURANCE COVERAGE**

7. Is your current coverage:  Claims-made Retro Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Occurrence  No Current Coverage  
 If no current coverage please explain reason: \_\_\_\_\_

8. List professional liability carried for each of the past five years:

Carrier & Policy Number	Limits of Liability	Deductible	Premium	Expiration Date	Claims Made	Occurrence
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

9. Please explain any gaps in insurance coverage over the past 5 years: \_\_\_\_\_

**IV. REQUESTED COVERAGE**

10. If your current coverage is claims-made, do you request Prior Acts Coverage?  Yes  No

11. Proposed Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

12. a. Requested Limits of Liability (Each Incident/ Annual Aggregate):

- \$100,000/ \$300,000  \$500,000/ \$1,000,000  
 \$200,000/ \$600,000  \$1,000,000/ \$1,000,000  
 \$250,000/\$750,000  \$1,000,000/ \$3,000,000  
 Other \_\_\_\_\_

b. Requested Deductible

- \$0  
 \$5,000  
 \$10,000  
 \$15,000

13. Are you requesting that your corporation or partnership entity (if applicable) be listed as a named insured and covered on a shared limit basis at no additional charge?  Yes  No

14. If you are an employee, are you requesting the entity you are employed by to be added as an additional insured on your policy?  Yes  No

15. If you utilize independent contractors in your practice, do you wish to purchase coverage for your vicarious liability with respect to their rendering of professional services for your practice?  Yes  No

If yes, provide the following information for each individual to be listed on the policy:

Name	Specialty	Has own insurance?	Insurance Company	Limits of Liability
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

## V. PRACTICE PROFILE

16. Please complete the table below to include the number of full time or part time employed personnel that work within your practice, and verify that they are licensed/certified:

Type	#	Check if Licensed or certified	Number of Hours per Week	Indicate if Employee (E) or Independent Contractor (IC)	Do they currently have Insurance?
Dietician/Nutritionist		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chiropractic Assistant/Technician		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acupuncturist		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Massage Therapist		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
MD/OD		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapist		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapist Aide/Asst		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapist		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapist Aide/Asst		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
X-Ray Technician		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:		<input type="checkbox"/>		<input type="checkbox"/> E <input type="checkbox"/> IC	<input type="checkbox"/> Yes <input type="checkbox"/> No

17. Please check each of the following procedures performed by you or someone else in your practice. Indicate with a check those that represent more than 5% of your practice time and for those indicate the approximate percentage or your practice time that procedure represents.

Check if performed	Check if more than 5% of time	% of practice time if more than 5%	Procedure
<input type="checkbox"/>	<input type="checkbox"/>		Adjustment (Subluxation Correction)
<input type="checkbox"/>	<input type="checkbox"/>		X-Ray (Other than therapy)
<input type="checkbox"/>	<input type="checkbox"/>		Ice/Heat
<input type="checkbox"/>	<input type="checkbox"/>		Electrical Stimulation
<input type="checkbox"/>	<input type="checkbox"/>		Reflex Testing
<input type="checkbox"/>	<input type="checkbox"/>		Extremity Adjustment
<input type="checkbox"/>	<input type="checkbox"/>		Non-Invasive Para Spinal EMG
<input type="checkbox"/>	<input type="checkbox"/>		Traction
<input type="checkbox"/>	<input type="checkbox"/>		Ultrasound
<input type="checkbox"/>	<input type="checkbox"/>		Hair Analysis
<input type="checkbox"/>	<input type="checkbox"/>		Orthopedic Testing
<input type="checkbox"/>	<input type="checkbox"/>		Diathermy
<input type="checkbox"/>	<input type="checkbox"/>		MRI, CT Scans, and EKG (performed in your office)
<input type="checkbox"/>	<input type="checkbox"/>		Galvanic Acupuncture
<input type="checkbox"/>	<input type="checkbox"/>		Urinalysis
<input type="checkbox"/>	<input type="checkbox"/>		Drawing Blood for Diagnosis and Analysis
<input type="checkbox"/>	<input type="checkbox"/>		Sports Chiropractic (treatment of injuries of high profile athletes or as a team doctor for organized amateur and professional sports teams)
<input type="checkbox"/>	<input type="checkbox"/>		Colon Irrigation
<input type="checkbox"/>	<input type="checkbox"/>		Casting and Broken Bones
<input type="checkbox"/>	<input type="checkbox"/>		Invasive Electromyography (EMG)
<input type="checkbox"/>	<input type="checkbox"/>		Homeopathy
<input type="checkbox"/>	<input type="checkbox"/>		Iridology
<input type="checkbox"/>	<input type="checkbox"/>		Manipulation Under Anesthesia
<input type="checkbox"/>	<input type="checkbox"/>		Minor Surgery
<input type="checkbox"/>	<input type="checkbox"/>		Breast Gynecological Exams
<input type="checkbox"/>	<input type="checkbox"/>		Diagnosis and Treatment of Medical Conditions Outside the Scope of Chiropractic
<input type="checkbox"/>	<input type="checkbox"/>		Acupuncture * Provide additional information in Question 18 below.
<input type="checkbox"/>	<input type="checkbox"/>		Massage Therapy * Provide additional information in Question 19 below.
<input type="checkbox"/>	<input type="checkbox"/>		Other (PLEASE DESCRIBE: _____)

18. a. Are you or anyone in your practice, certified to practice acupuncture?  Yes  No  
 b. Name of acupuncturist: \_\_\_\_\_ c. State License #: \_\_\_\_\_  
 d. Attach a copy of State Certification
19. a. Are you or anyone in your practice certified as a Massage Therapist?  Yes  No  
 b. Name of Massage Therapist: \_\_\_\_\_ c. State License #: \_\_\_\_\_  
 d. Attach a copy of State Certification if required by the State.
20. Do you refer patients to other health care providers for diagnosis or treatment of medical conditions that are outside the scope of Chiropractic?  Yes  No
21. Do you provide professional services under any capacity other than those for which you are licensed as a Chiropractor?  Yes  No  
 If yes, describe: \_\_\_\_\_
22. Do you consult, teach or train outside your practice?  Yes  No  
 If yes, please explain (attach separate sheet if necessary): \_\_\_\_\_
23. Do you have preceptors or postceptors involved in your practice?  Yes  No
24. Relating to chiropractic services:
- a. Do you perform outside peer reviews or Independent Medical Exams?  Yes  No  
 If yes, percentage of practice time: \_\_\_\_\_ Provide details: \_\_\_\_\_
- b. Do you have a contract with an insurance company to do peer reviews?  Yes  No  
 If yes, provide details: \_\_\_\_\_
- c. Do you provide consulting services outside your Chiropractic practice?  Yes  No  
 If yes, provide details: \_\_\_\_\_
- d. Do you serve on outside Chiropractic boards?  Yes  No  
 If yes, indicate boards you serve on: \_\_\_\_\_
25. Do you draw blood for diagnostic purposes?  Yes  No
- a. If yes, do you test for:
- b. Nutritional deficiencies  Yes  No Infections  Yes  No Other? (please describe): \_\_\_\_\_
- c. If Yes, do you send samples out to a third party for diagnosis?  Yes  No
26. Do you dispense or prescribe: (If yes to any of the below, attach a detailed explanation.)
- a. Any Herbs?  Yes  No c. Any dietary regimen?  Yes  No  
 b. Any Vitamins?  Yes  No d. Any nutritional supplements?  Yes  No
27. a. Do you utilize X-Rays in your practice?  Yes  No  
 If Yes,
- b. Do you own your own X-ray unit?  Yes  No
- c. Number of X-rays per month: \_\_\_\_\_
- 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

## VI. RISK MANAGEMENT

28. Have you completed a Risk Management seminar in the last twenty-four (24) months relative to any of the following risk management topics: patient communication, informed consent, confidentiality of records, litigation and related issues?  Yes  No  
 If yes, provide a copy of your certificate of completion for credit consideration.
29. Are patient's files documented each visit?  Yes  No
30. Are complete Chiropractic records kept on all patients?  Yes  No
31. Are your patient's records hand written?  Yes  No
- a. If not hand written, do you dictate and initial after transcribed?  Yes  No
- b. Or, do you use a software program for creating and updating patient records?  Yes  No
32. Are informed consent forms used?  Yes  No
33. Is the "informed consent" discussion documented in the patient's medical record?  Yes  No
34. Do you require signed release forms for the release of records?  Yes  No

35. Does your practice include written Patient Safety Policy /Practice Standards?  Yes  No
36. Do you enter into arbitration or similar agreements with your patients?  Yes  No
37. Do you use a collection agency on late accounts?  Yes  No
38. Please indicate each of the procedures you use when hiring professionals and clinical support staff to provide patient care services in your office:
- Verifying educational background       Check personal references       Check previous employers
- Check criminal history       Check for any pending license suspensions or revocations

### IX. UNDERWRITING INFORMATION

NOTE: If the answer to any of the following underwriting information questions is yes, please provide an explanation on a separate sheet.

39. Has your professional liability insurance ever been canceled, declined, non-renewed, or accepted only on special terms?  
THIS QUESTION IS NOT APPLICABLE TO MISSOURI APPLICANTS. MISSOURI APPLICANTS DO NOT ANSWER.  Yes  No
40. Has your chiropractic license ever been suspended, revoked, voluntarily surrendered, or subject to probation in any state?  Yes  No
41. Have you ever been convicted of a crime in any state or country?  Yes  No
42. Have you ever had any licensing board or professional ethics body 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

### X. CLAIMS HISTORY

43. 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 complete a Claims Supplement form and attach to this application.
44. Are there any circumstances or incidents of which you are aware that may result in a 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 explain: \_\_\_\_\_
45. 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 explain: \_\_\_\_\_

### FRAUD PREVENTION & SIGNATURE

**NOTICE TO ARKANSAS APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment for 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 Agencies.

**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 of the third degree.

**NOTICE TO HAWAII APPLICANTS:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**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 purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NOTICE TO MINNESOTA APPLICANTS:** A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**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 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 civil fines and criminal 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 the 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.

**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 & 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.

**NOTICE TO ALL APPLICANTS:**

**BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT. SUCH AN ACT IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

**THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT**

**THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.**

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Signature of Applicant

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Signature of Agent/Broker

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Title

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Date

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Date

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Signed by Licensed Resident Agent  
(Where Required By Law)