PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

APPLICATION FOR CHIROPRACTORS PROFESSIONAL LIABILITY INSURANCE
(Claims Made and Reported Basis)

APPLICANT'S INSRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner, or officer.
3. A separate Application must be completed, signed and dated by each Chiropractor.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

REQUESTED EFFECTIVE DATE: _____

1. APPLICANT INFORMATION

a. Full name of applicant and Degree designation(s)

_____

b. Principal business premise address: _____

(street) *(County)*

_____

(City) *(State)* *(Zip)*

(Please attach list of additional office addresses)

c. Telephone Number Home ( ) _____ Office ( ) _____

d. Personal Information: _____ _____

Birth Date MM/DD/YR *Social Security Number*

e. Email address:_____ Website:_____

F. License Information:

(i) Chiropractic License Number(s) _____

(ii) State(s) Licensed _____

(iii) License Expiration Date_____ _____

(iv) Are you licensed to practice any other health care practices: ☐ Yes ☐ No

If Yes, Please Circle: MD DO DPM ND RN RPT LAC Midwife

Other: _____

g. Education: _____ _____

Chiropractor College or University, City, State, County *Year of Graduation*

h. Requested Limits of Liability (Limits in policy will govern Coverage).

☐	$100,000 per claim; $300,000 annual aggregate	☐	$ 500,000 per claim; $1,000,000 annual aggregate
☐	$200,000 per claim; $600,000 annual aggregate	☐	$ 500,000 per claim; $1,500,000 annual aggregate Texas
☐	$250,000 per claim; $750,000 annual aggregate	☐	$1,000,000 per claim; $3,000,000 annual aggregate
		☐	$1,300,000 per claim; $3,900,000 annual aggregate NY only

i. Any cosmetic procedures or treatments: ☐ Yes ☐ No

If yes, Describe:

2. APPLICANT PRACTICE

a. Where have you practiced your profession since graduation?

(i) In _____ (ii) In _____
State *State*

(iii) In _____ (iv) In _____
State *State*

b. Please check one box describing your practice and fill in the blanks using an attached sheet, if necessary.

(i) ____ Sole proprietorship (unincorporated _____
Business Name

(ii) ____ Professional corporation _____
Corporate Name

Do you want corporate coverage? ☐ Yes ☐ No

(iii) ___ Partnership _____
Partners' Names *Partnership Names*

(iv) ___ Employee, associate or independent contractor with _____
Employer's Name

c. Please tell us how many:

(i) Hours per week you practice chiropractic: _____

(ii) Patient visits you handle weekly: _____

d. Approximate gross annual income from your practice:

☐ Less than $50,000 ☐ $100,000 to $149,000 ☐ $200,000 or more

☐ $50,000 to $99,000 ☐ $150,000 to $199,999

e. Do you anticipate any changes in your practice in the next 12 months? ☐ Yes ☐ No

If Yes, please attach details.

3. Procedures

a. Please indicate those procedures or devices used in your practice:

		Yes	No			Yes	No
(i)	General Meric adjusting			(xvii)	Acupuncture		
(ii)	Upper cervical specific			(xviii)	Massages		
(iii)	Instrumental adjusting			(xix)	Short wave diathermy		
(iv)	Gonstead/diversified			(xx)	Kinesiology		
(v)	Direct non-force			(xxi)	Mechanical traction		
(vi)	Sacro-occipital			(xxii)	Whirlpool		
(vii)	Hydroculator/heat packs			(xxiii)	Stressology		
(viii)	Electrical Stimulation			(xxiv)	Gemstone therapy		
(ix)	Ice-cryotherapy			(xxv)	Toftness device		
(x)	Trigger point			(xxvi)	Colonic irrigations		
(xi)	Cold laser			(xxvii)	Treat cancer		
(xii)	Activator			(xxviii)	Treat epilepsy		
(xiii)	Galvanic			(xxix)	MUA		
(xiv)	Ultraviolet			(xxx)	Prenatal care & normal deliveries		
(xv)	Ultrasound						
(xvi)	Internal coccyx adjustment						

b. If the answer to any of the questions below is No, please attach details. Do you:

(i) Use the Georges test, the Vertebral Artery Ischemia Test or the Cerebrovascular Craniocervical Function Test when initially seeing a patient or when seeing a patient you have not seen for six months? Yes ☐ No ☐

If No, please describe how you assess vascular flow: _____

If an unusual finding results, do you refer the patient to the appropriate medical practitioner? Yes ☐ No ☐

(ii) Make a differential diagnosis? | | |

(iii) Always record the patient's account of his/her progress? | | |

(iv) Always record objective findings? | | |

(v) Always record details of treatment procedures? | | |

c. If the answer to any of the questions below is YES, please attach details. Do you:

(i) Use acupuncture? | | |

If yes, do you use the National Council of Acupuncturists (NCCA) clean needle technique? | | |

Date Last NCCA exam taken and passed:_____

If No, do you use disposal needle?_____

If No, please attach details: _____

(ii) Dispense or prescribe: Drugs? | | |

Vitamins? | | |

(iii) Use x-ray or imaging in treatment determination? | | |

(iv) Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? | | |

(v) Perform investigational or experimental research or therapy on human patients? | | |

4. APPLICANT OPERATIONS

a. (i) Do you use a collection agency: | | |

If Yes, please give name of agency:_____

(ii) Has the agency authority to file a collectin suit at it's discretion? | | |

b. (i) Do you advertise your professional services in any manner (other than a simple listing in a telephone directory? | | |

(ii) Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? | | |

If Yes, please attach details and submit copy of ALL advertisements.

5. STAFF

a. Please indicate the number of professional employees, volunteers and independent contractors. (If NONE, STATE NONE) _____

		No of Employees and Volunteers	No of Independent Contractors
(i)	Chiropractor		
(ii)	Chiropractor Assistant		
(iii)	Nurses, Licensed Practical		
(iv)	Nurses, Practitioner		
(v)	Nurses, Registered		
(vi)	X-ray Technician		
(vii)	Laboratory Technician		
(viii)	Physical Therapist		
(ix)	Massage Therapist		
(x)	Student/Preceptors		
(xi)	Other:_____		

NOTE: If you require any of the above to be Named Insureds, please submit a separate application for each individual.

	Yes	No
b. Are all the above individuals licensed in accordance with applicable state and federal regulations? If No, please attach explanation.		
c. Are you engaged in any business other than the practice of chiropractic? If Yes, please attach details.		
d. Do you own (wholly or in part), operate or administer any hospital, nursing home, surgi-center, clinic or other facility where healthcare services are customarily rendered?		

If Yes, please attach details.

e. Do you or the entity named in Question 2(b) contract to provide professional services to any individual, entity, or government entity? ☐ ☐
If Yes, please attach details.

f. Are you affiliated with any hospitals? ☐ ☐
If Yes, please provide name(s), city, state

g. Please list any professional societies/organizations in which you are currently a member:

6. APPLICANT HISTORY/CLAIMS

		Yes	No
a.	Have you or any of your employees: (Attach detailed explanation for any Yes answers)		
(i)	Ever been the subject of disciplinary or investigative proceedings or reprimand by a government or administrative agency, hospital or professional association? (Attach copy of Complaint and Consent Order documents, if applicable).	☐	☐
(ii)	Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	☐	☐
(iii)	Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required evaluation of an alleged mental condition and/or alcohol or drug addiction?	☐	☐
(iv)	Ever had any state professional license refused, suspended, revoked, renewal refusal or accepted only on special terms or ever voluntarily surrendered same?	☐	☐
(v)	Ever had any professional liability insurance canceled, declined, renewal refused or accepted only on special terms?	☐	☐
(vi)	Ever failed any professional licensing examination?	☐	☐
(vii)	Any chronic physical illness or defect?	☐	☐
b.	Has any claim or suit been brought against you and/or any of your employees? If Yes, please complete a Supplemental Claim Form for each claim or suit.	☐	☐
c.	Are you aware of any circumstances which may result in a malpractice claim or suit against you or any of your employees? If Yes, please complete a Supplemental Claim Form, giving details for each circumstances.	☐	☐

d. Please list prior professional liability insurance for each of the past five years. If none, state none.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Exp. Mo/Day/Yr.	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form? Yes	No
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐

e. REQUESTED RETROACTIVE DATE: If prior professional liability insurance was on a claims made basis, advise the retroactive date of coverage:_____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

I AUTHORIZE any professional society, prior or present insurer, business or professional associate, licensing board, governmental entity, corporation, partnership, organization, institution or person that may have any record or knowledge concerning any claim or any of the statements and answers made herein to release such information to the underwriting manager, Company and/or affiliates thereof. I authorize the use of a copy of this authorization in place of the original.

Printed Name of Applicant	*Title (Officer, Partner, etc.)*
Signature of Applicant	*Date*

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

Professional Liability Claims Information

(Must be printed or typed)

Complete one form for each case. Copies may be made as needed.

Insurance Carrier:_____ **Patient Name:** _____

Date of Occurrence:_____ **Date of Suit:** _____

Location of Incident: _____

Relationship to Patient (Treating Chiropractor, Consultant, etc.) _____

Primary Defendant:_____ **Co-Defendant:** _____

Patient Outcome:_____

_____

Allegations made about care rendered: _____

_____

_____

_____

_____

Claim Status (Open, Closed, Pending):_____ **Date:**_____

If closed, indicate method of closing: (Circle below)

DISMISSAL **SETTLED** **JUDGMENT** **CASE-DROPPED**

Amount of settlement/judgment:_____ **Date:**_____

Chiropractor (print Name):_____ **Date:**_____

I understand that the information submitted here becomes a part of my insurance application and is subject to the same representations and conditions.

Signature of Applicant:_____ Date:_____