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One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

MALPRACTICE INSURANCE
CHIROPRACTOR PROFESSIONAL LIABILITY APPLICATION

A. PERSONAL

1. Full Name: Last:_____ First:_____ Middle:_____

2. Date of Birth:_____ Age:_____ Male: ☐ Female: ☐

3. Home Address:_____
   City:_____ State:_____ Zip Code:_____

4. Home Phone:_____ Website: www._____

5. Chiropractic License Number:_____ State of Issuance:_____

6. As a Doctor of Chiropractic, you practice as a **(SELECT ONLY ONE)**:

   ☐ SOLE Practitioner ☐ CORPORATE Shareholder

   ☐ PARTNERSHIP ☐ ASSOCIATE (Employed / Contracted)

B. PRACTICE

1. Office Address:_____
   City:_____ County:_____
   State:_____ Zip Code:_____

2. Office Phone:_____ Fax:_____
   Cell Phone:_____ e-Mail:_____

3. Years at Location:_____ FEIN:_____

4. Do you have a financial responsibility to any other practice location(s)? ☐ Yes ☐ No
   (If Yes, address(es) and explanation on a separate sheet.)

5. Are you incorporated? ☐ Yes ☐ No

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C. STAFF / ASSOCIATES

1. Indicate the number of personnel in your practice location(s) as follows (mark zero if not applicable):

Clerks / Receptionists _____ Technicians _____

Other non-licensed professionals: (attach names and specialties)

_____

2. Approximately how many patient visits are treated by you and/or by the above staff during a typical Practice week?_____

3. Approximately how many hours of face time do you spend during a typical Practice week?_____

4. Other than noted above, are there any other licensed medical professionals that are associated with your practice? ☐ Yes ☐ No
(If Yes, give names, specialties, and extent of association on a separate sheet)

5. Do you perform initial and interim examination of patients? ☐ Yes ☐ No

6. Do you use progress notes that include subjective and objective findings in charting patient visits? ☐ Yes ☐ No

D. NEW PATIENT PROTOCOL

1. When a new patient presents to you for chiropractic care, prior to treatment do you: (must answer each)

Obtain a medical history? ☐ Yes ☐ No

Formulate a differential diagnosis for treatment? ☐ Yes ☐ No

Obtain signed consent to treat? ☐ Yes ☐ No

Discuss the treatment planned? ☐ Yes ☐ No

Perform a physical exam? ☐ Yes ☐ No

Discuss the patient's financial responsibility? ☐ Yes ☐ No

2. With new patients, percent (approximately) that present to you with the following major complaint(s) of (can exceed 100%):

Cranial _____ Cervical _____ Lumbar _____
Extremity _____ Dorsal or Thoracic _____ Other: _____

3. Approximately how many new patients are treated by you during a typical practice week?_____

E. MANIPULATION

1. Check any / all general techniques and specific procedures used in patient care that are listed below:

General Meric Adjusting:

☐ Meric ☐ Gonstead ☐ Diversified
☐ Motion Palpation ☐ Pierce-Stillwagon ☐ Thompson

Upper Cervical Specific:

☐ Toggle ☐ Hole In One
☐ Grostic ☐ Orthogonal

Instrumental Adjusting:

☐ Life Cervical ☐ Pettibon ☐ Spinal Bio Physics
☐ Activator ☐ Equalizer

Kinesiology:

☐ Bennett Reflexes ☐ Reflexology ☐ Applied Kinesiology

Direct Low-Forge:

☐ Direct Non-Force Technique ☐ Jenness ☐ Freeman
☐ Trigger Points ☐ Receptor Tonus ☐ Toftness

Sacro-Occipital: _____

Logan Basic: _____

Cox-Mc Manis: _____

F. THERAPIES

1. Do you do Meridian therapy? ☐ Yes ☐ No
(If Yes, check all you do):

☐ Acupressure ☐ Electric Acupunture
☐ Needle Acupuncture ☐ Laser Acupuncture

2. Check any / all physiotherapies used in patient care that are listed below:

Traction:

☐ Mechanical ☐ Motorized ☐ Inversion ☐ Intersegmental

Equipment:

☐ Short-Wave Diathermy ☐ Low / Hi Volt Galvanism
☐ Tens Current ☐ Inferential
☐ Infra Red ☐ Ultraviolet
☐ Accuscope ☐ Ultrasound
☐ Whirlpool ☐ Muscle Stimulating Current

G. X-RAYS

1. Do you provide your own x-rays at your practice location? ☐ Yes ☐ No
(If Yes, answer below)

Does everyone who takes x-rays have proper and current certification / training? ☐ Yes ☐ No

Do you always use the 10-day rule for x-raying females of child-bearing age? ☐ Yes ☐ No

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H. SPECIALTIES

1. In your practice of chiropractic, do you ever provide patient care as follows: (must answer each)

Venipuncture:	☐ Yes	☐ No	Obstetrics:	☐ Yes	☐ No
Reichian Therapy:	☐ Yes	☐ No	Invasive Surgery:	☐ Yes	☐ No
Sinus irrigation:	☐ Yes	☐ No	Chelation Therapy:	☐ Yes	☐ No
Gynecological Exams:	☐ Yes	☐ No	Colonic Irrigation:	☐ Yes	☐ No
Proctological Exams:	☐ Yes	☐ No			

I. REFERRALS

1. Do you have an established and working relationship with any of the medical specialists listed below? (Check all that apply)

☐ Neuro Specialist ☐ Orthopedist ☐ Radiologist
☐ Vascular Specialist ☐ Internist ☐ General Practitioner

2. Do you have an established relationship to refer directly for diagnostic imaging? ☐ Yes ☐ No

J. MEDICAL POLICY

Select the options that best describe your medical policy to the situation listed below: (only one per selection group)

When a patient first presents with signs and/or symptoms of cerebrovascular insufficiency, do you:

1. Assess cerebral flow (i.e. palpate pulses, ausculate for bruits, Adson maneuver, etc.) prior to any cervical spine manipulation:

☐ Always ☐ Usually ☐ Occasionally ☐ Never

2. Document your findings prior to any cervical spine manipulations:

☐ Always ☐ Usually ☐ Occasionally ☐ Never

3. Refer the patient to a specialist and/or non-invasive diagnostic imaging if the signs and/or symptoms are not resolved with normal local care:

☐ Always ☐ Usually ☐ Occasionally ☐ Never

K. BUSINESS POLICY

Check any / all of fee and payment formats used in patient care that are listed below:

1. Fees are collected:

☐ Cash/Check ☐ Charge Card ☐ Barter
☐ Statements ☐ In Advance
☐ On insurance assignment (☐ With / ☐ Without out of pocket)
☐ On case contract (☐ Installments ☐ In advance)

2. No cost services are allowed:

☐ Indigent ☐ Introductory ☐ Referral
☐ Community Service ☐ Professional Courtesy ☐ Educational

3. Do you use a collection agency on past due accounts? ☐ Yes ☐ No

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L. EDUCATION

1. D.C. College:_____ Month / Year Graduated:_____

2. Are you currently a member of and/or affiliated with any chiropractic Association and / or Society? ☐ Yes ☐ No
(If Yes, identify)

_____

3. List any special chiropractic credentials and/or status that you have obtained:

_____

M. CONFIDENTIAL INFORMATION

Answer the following questions and if your response is Yes, then describe on a separate sheet.

1. Are you gainfully engaged / employed in any other profession and / or professional activity? ☐ Yes ☐ No
2. Have you ever had professional liability insurance canceled or renewal refused? ☐ Yes ☐ No
3. Have you ever used an intoxicant, narcotic, or other psychoactive or depressant drug to the extent that it has interfered with your ability to perform professional duties? ☐ Yes ☐ No
4. Have you ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
5. Have you ever been involved in the loss or removal of a medical provider number? ☐ Yes ☐ No
6. Have you ever had any state license to practice chiropractic revoked, suspended, or involuntarily surrendered? ☐ Yes ☐ No

N. CLAIMS HISTORY

Provide patient names, dates, circumstances, details, status, etc. on a separate sheet for any "Yes" answer below.

1. Has the Applicant been involved in any malpractice claim(s) or suit(s)? ☐ Yes ☐ No
2. Is the Applicant aware of any incidents which have occurred that might give rise to a claim in the future? ☐ Yes ☐ No
3. Is the Applicant aware of any other circumstances, injury, accident, error, omission, or offense which may result in a claim being made against the Applicant or any of its predecessors in practice or any of the past or present partners, owners, officers, or employees? ☐ Yes ☐ No

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O. INSURANCE INFORMATION

1. Do you currently have Malpractice Insurance? ☐ Yes ☐ No
   If Yes, who is the carrier?_____
   Is coverage Claims-Made or Occurrence?_____

2. What is your current Retroactive Date, if any? Retroactive Date:_____

3. What limits of coverage are you applying for?
   ☐ $100,000 / $300,000 ☐ $200,000 / $600,000 ☐ $500,000 / $1.5M ☐ $1M/ $3M

4. What is your proposed effective date of coverage?_____

5. Do you currently have Premises Liability coverage? ☐ Yes ☐ No
   If Yes, who is the carrier?_____

6. Do you want coverage for your corporation, limited liability company or limited liability partnership? ☐ Yes ☐ No
   If Yes, what is the name of the entity?_____

P. PRACTICE WARRANTIES

1. **The undersigned Applicant warrants, as a condition precedent to coverage, that he/she will not do any of the following: practice obstetrics, perform procedures under 2 weeks of age, perform any invasive surgical procedure, and/or do acupuncture with needles.**

_____ _____
Signature Date

Q. MISCELLANEOUS ACKNOWLEDGEMENTS / AUTHORIZATION

1. I hereby authorize release and exchange of information between my medical association or society and their insurance consultants, any hospital I presently or previously held staff privileges with, and prior insurance carriers involving past and future underwriting and claims matters. I further agree that the organization releasing the information, its agents, servants and employees, shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors, omissions, or mistakes contained in such released information.

2. I understand that the policy being applied for does not cover liability for others which I may have assumed under any contract or agreement. I understand that the policy being applied for is limited to claims for professional liability and that it does not provide coverage for property insurance, comprehensive general liability, owned or non-owned automobiles, premises liability, or any other coverage.

3. Submission of this application (signed or unsigned) to the company – with or without permission – does not bind insurance coverage. Rather, insurance coverage will be put in force only when the insurance company issues a written "Confirmation of Coverage' or insurance policy. The insurance company will not issue a "Confirmation of Coverage" until after it has:

   a. Received and approved a completed application from you, and
   b. Issued a written premium quotation to you based upon your application and certain other information, and
   c. Received from you a written request to place coverage in effect, and
   d. Received from you **either** 100% of the correct premium, taxes, and fees which were quoted in the written premium quotation discussed in "3b" above, or 25% of the correct premium and 100% of the taxes, and 100% of the fees which were quoted in the written quotation discussed in "3b".

_____ _____
Signature Date

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MISCELLANEOUS WARRANTIES

1. The undersigned Applicant warrants that if the Applicant selects the insurance which is provided on a claims made policy, then they are aware of the following: It only covers occurrences which take place during the policy period and then only if the claim is first made to the company during the policy period or during a 60-day reporting period commencing with the termination of the policy. The policy allows, for an additional premium, an extended reporting period option. A sample policy is available on request.

_____ _____

Signature Date

2. The undersigned Applicant warrants, as a condition precedent to coverage, that he/she will provide immediate written notice to the insurance company, prior to the inception of any coverage which may be offered by the insurance company, of any occurrence, event, claim or suit of which the Applicant becomes aware, subsequent to completion of this application, but prior to the inception of any coverage which may be offered by the insurance company.

The Applicant further understands that failing to provide written notice to the insurance company, as provided in Paragraph 1 above, will cause any coverage to be rescinded.

3. The undersigned Applicant has read and understands this application and warrants, as a condition precedent to coverage, that all statements set forth herein are true, complete and accurate. The insured understands that this application will be relied upon by the insurance company as it determines whether or not it will offer coverage (and, if so, the price at which such coverage will be offered). As such, this application will become part of the insurance contract (if such a contract is ultimately issued) and any false representation made on this application will cause any coverage to be rescinded.

_____ _____

Signature Date

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FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

FRAUD NOTICE STATEMENTS

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 AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: 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.

APPLICABLE IN FLORIDA AND OKLAHOMA: 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 (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN NEW YORK: 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

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ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the question number to which you are referring.

Signature

Date