NATUROPATHIC INSURANCE
NEW BUSINESS APPLICATION

I. APPLICANT INFORMATION (Please complete separate application for each Professional Provider if applicable)

Name: ____ ND ☐ NMD ☐ L.Ac ☐ DC ☐ MD ☐ LMP ☐ LMT ☐ ARNP ☐ R.Ph ☐ FABNO ☐ CNM ☐ DAOM ☐ MAcOM ☐ RH ☐ DHANP ☐ Other ______________________

1. Mailing Address ______________________________ City______________ State _____ ZIP ____________
2. Date of Birth ___________Phone ( ) ___________ Fax ( ) ____________ Cell ( ) _____________
3. Website: ______________________________________ Email ________________________________
4. License Number _____________ Medical School _____________________________ Years in Practice _______
5. Have you completed any post graduate internship or residency programs? YES ☐ NO ☐ Year completed ____________
6. Member of local state association? YES ☐ NO ☐ Member of AANP? YES ☐ NO ☐.
7. Do you have a Personal or Professional Corporation YES ☐ NO ☐
8. Name of Corporate entity ____ Total # of Employees ______
9. If you use a dba please provide Name ____

II. PRACTICE INFORMATION

10. Are you self-employed? YES ☐ NO ☐ IF NOT PLEASE COMPLETE QUESTIONS 11 thru 14
11. Name, address, and type of employer: ____
12. Are you an Employee ☐ or an Independent Contractor? ☐ If you provide services anywhere else, please list in Remarks.
13. Does your employer carry Professional Liability Insurance? YES ☐ NO ☐ DON'T KNOW ☐. Are you covered as an additional Insured on your employer's policy? YES ☐ NO ☐ **If so please provide a certificate of insurance evidencing coverage.**
14. Do you cover for other providers in the practice and/or share PTs? YES ☐ NO ☐ Do you supervise the professional services of any other professionals? YES ☐ NO ☐ If so, how many? _________ Describe in detail your supervisory responsibilities:
    ____
15. Do you treat children under the age of 18? YES ☐ NO ☐ What % of your practice are minors? _______________
16. Do you treat neo-nates? YES ☐ NO ☐ If so, at what age do you assume care? ____________________________
17. In what areas of practice do you specialize or concentrate? ____
18. Do you use Intrastate or Interstate Telemedicine in your practice? If yes please explain in detail in Remarks.
19. Do you sell Nutraceuticals or supplements under your own brand? YES ☐ NO ☐ Annual sales $ __________________
20. Have you ever been the subject of a State investigation or a Medical Board complaint? If so please attach a separate statement that details the complaint, the outcome, and any fine or penalty that was assessed.
21. DEA License # if applicable ______________Are you licensed in multiple states? YES ☐ NO ☐ If so are you aware that you need a separate DEA license for each state in order to be in compliance? YES ☐ NO ☐
22. Current Insurer ______________________ Average # of PTs seen per week _________
    Requested Retroactive Date __________ (from current policy declarations page) Requested Effective Date __________

Please select the modalities that you perform in your practice to give us a better idea of your scope. If you do something that is not listed please fill in on a blank space. Thank you!

☐	Acupuncture	☐	Laser Cool Sculpting	☐	Pediatrics
☐	BOTOX	☐	Laser Infrared	☐	Pre-Natal Care
☐	Bio Identical Hormone RT	☐	Local Anesthetic	☐	Post Natal Care
☐	Dermal Fillers	☐	Medical Director Duties	☐	PRP Therapy
☐	EDTA (oral/rectal)	☐	Medical Marijuana	☐	Prolotherapy
☐	EDTA (IV)	☐	Mesotherapy	☐	RF Wrinkle reduction
☐	Gynecology	☐	Minor Office Surgery	☐	Sclerotherapy
☐	hCg for BHRT	☐	NeuroCranial Restructuring	☐	Stem Cell Therapy
☐	hCg for weight loss patients	☐	Nutritional Therapy	☐	Trigger Point Injections
☐	Homeopathy	☐	Oriental Medicine	☐	
☐	Holistic Medicine	☐	Oxygen Therapy	☐	
☐	Hyperbaric Oxygen Therapy	☐	Ozone Therapy	☐	
☐	IV Nutrient Therapy	☐	Pain Management no opiates	☐	
☐	Laser Esthetic	☐	Pain Management with Opiates	☐	

III. REPRESENTATIONS AND WARRANTIES

This application must be signed by an authorized partner, officer or other principal of Applicant as shown in Question I.1 of this application. By signing this Application, Applicant represents and warrants the following:

a. The statements in the Application or Renewal Application furnished to the Company are accurate and complete;
b. Those statements furnished to the Company are Representations Applicant makes on behalf of all proposed insureds;
c. Those Representations are a material inducement to the Company to provide a premium proposal;
d. If a policy is issued, the Company will have issued this policy on reliance upon those Representations;
e. If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report to the Company in writing; and
f. The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company
g. Applicant agrees that there is no coverage in this policy for the practice of Obstetrics, Midwifery, or Surgery (other than minor Office Surgery if allowed by your scope of practice).

I am licensed or duly authorized in the State of _________________ where I provide Professional Services, and I DO HEREBY WARRANT the truth to my answers to the above questions, and that I have not withheld any information which is calculated to influence the judgment of the company in considering this application for insurance.

_______________________________________ ____ ______________

Name of Applicant **Applicant Signature** **Date**

Please provide copies of the following documents with this application:

Current policy Declarations Pages for Professional Liability including Schedule of Additional insureds and their retro dates.

Copy of DEA License(s), (if active) and all Medical License(s) and current and prior company loss runs if any reported claims or incidents

Copy of Membership in Good Standing from State Association to qualify for 10% premium Discount

IV. FRAUD WARNINGS

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.

(Not applicable in CO, ME, DC, MD, OR WA)

APPLICABLE IN CO

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 DC AND MD

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison. *Applies in MD only

APPLICABLE IN ME AND WA

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 and denial of insurance benefits. *Applies in ME only.

APPLICABLE IN OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

REMARKS

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