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NATUROPATHIC INSURANCE RENEWAL APPLICATION

Aegis Insurance Associates

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. Years in Practice _____ Phone ( ) _____ Fax ( ) _____ Cell ( ) _____
3. Website: _____ Email _____
4. Have you completed any post graduate internship or residency programs? YES ☐ NO ☐ Year completed _____
5. Member of Resident State Association? YES ☐ NO ☐ AANP Member? YES ☐ NO ☐ Other _____
6. Do you have a Personal or Professional corporation? ☐ YES ☐ NO Please provide Name of Corporate entity: _____ Total # of Employees _____
7. Do you use a dba? YES ☐ NO ☐ Name _____

II. PRACTICE INFORMATION

8. Have you made any changes to your practice or added procedures since your last application? YES ☐ NO ☐ Please explain: _____
9. Are you self-employed? YES ☐ NO ☐ Independent Contractor? YES ☐ NO ☐ Average # of PTs seen per week _____ Name, and address of employer (if employed): _____
10. 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.**
11. 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: _____
12. If you provide services anywhere else, please list in Remarks.
13. Do you treat children under the age of 18? YES ☐ NO ☐ What % of your practice are minors? _____
14. Do you treat neo-nates? YES ☐ NO ☐ If so, at what age do you assume care? _____
15. In what areas of practice do you specialize or concentrate? _____
16. Do you use Intrastate or Interstate Telemedicine in your practice? If yes please explain in detail in Remarks.
17. Do you sell Nutraceuticals or supplements under your own brand? YES ☐ NO ☐ Annual sales $ _____
18. 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.
19. 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 to be in compliance? YES ☐ NO ☐ Please provide copy of DEA License(s)

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	☐	Pediatric Care
☐	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:

Copy of DEA License(s), (if not provided prior)and current and prior company loss runs if any reported claims or incidents

Copy of Membership in Good Standing from Resident 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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