

## Acupuncture Professional Healthcare and Business Liability Insurance Application

**NOTHING IN THIS APPLICATION SHOULD BE INTERPRETED TO MEAN THAT COVERAGE WILL BE OFFERED OR THAT ANY ITEMS REFERENCED IN QUESTIONS OR ANSWERS TO QUESTIONS WILL BE COVERED EVEN IF COVERAGE IS OFFERED AND BOUND. SOME RESPONSES MAY REQUIRE MORE SPACE THAN THAT PROVIDED IN THE APPLICATION ITSELF. PLEASE PROVIDE THOSE RESPONSES ON A SEPARATE PAGE AND ATTACH IT TO THIS APPLICATION.**

This application is for either Occurrence or Claims-Made and Reported coverage, as requested by the Applicant.

As used herein, the "Company" refers to Capitol Specialty Insurance Corporation.

### I. APPLICANT INFORMATION (Please complete for each Acupuncturist if applicable)

1.1	Proposed <b>First Named Insured</b> (This is how the name & address of the First Named Insured will read on the Declarations Page if coverage is bound with the Company.):		
	Name (include DBA):		
	Address:		
	City, State, Zip:		
	Phone:		
1.2	Website Address(es):		
1.3	Acupuncture License #		
1.4	Acupuncture College	Degree:	Year Graduated:
1.5	Practice Description	Sole Proprietorship <input type="checkbox"/> Professional Corp <input type="checkbox"/> Partnership <input type="checkbox"/> Association <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Employed Individual, List Employer:	
1.6	Please provide the total number of Applicant's employees:		
1.7	Are you requesting separate limits for your entity listed above in question 1.6 (if applicable): <input type="checkbox"/> Yes <input type="checkbox"/> No		

### II. PRACTICE INFORMATION

2.1	What year did you start practice?		
2.2	How many hours a week on average do you practice?		
2.3	Are you a current member of the National Guild of Acupuncturists and Oriental Medicine?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.4	Do you provide any other services besides the practice of acupuncture? (If Yes, please provide detail in an attachment.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.5	Are you Board Certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a Licensed Acupuncturist?		<input type="checkbox"/> Yes <input type="checkbox"/> No

### III. Current/Prior Coverage

3.1	Prior Professional Liability Insurance: (List below or please provide copy of expiring Dec page)				
	<b>Policy Period</b>	<b>Carrier</b>	<b>Limits</b>	<b>Premium</b>	<b>Claims-Made or Occurrence</b>
3.2	What is the retroactive date of the current policy? NOTE:				
3.3	Has any proposed insured ever applied for Professional Liability coverage and been denied, cancelled or non-renewed?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.4	Would you like to purchase General Liability coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

### IV. DESIRED LIMITS

4.1	Desired Limits:	
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Each Claim:	<input type="checkbox"/> \$100,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> Other _____
Aggregate Limit	<input type="checkbox"/> \$300,000 <input type="checkbox"/> \$600,000 <input type="checkbox"/> \$900,000 <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$3,040,000 <input type="checkbox"/> Other _____

## V. CLAIMS AND POTENTIAL CLAIMS INFORMATION

5.1	Is any proposed insured aware of any actual or alleged fact, circumstance, situation, error or omission, which can reasonably be expected to result in a Claim, suit or proceeding being made against Applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.2	Have the proposed insureds, or any of the proposed insureds' predecessors in business, affiliates, or past or present: partners, owners, officers, sales persons or employees been investigated and/or cited by any regulatory agency, certifying body, or other governmental entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**The policy for which the Applicant is applying, if issued, will not insure any claim, suit, proceeding or other matter disclosed, or which should have been disclosed, in response to the above; or any claim, suit proceeding or other matter that arises from any fact, circumstance, situation, demand, error or omission disclosed, or which should have been disclosed, in response to the above.**

5.3	If any of the answers to questions 5.1 or 5.2 above are "Yes", have all matters been reported to appropriate insurance carriers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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## VI. 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 AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, WA and WV).**

### APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV

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 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 FL AND OK

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)\*. \*Applies in FL only.

### APPLICABLE IN KS

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 commits a fraudulent insurance act.

### APPLICABLE IN KY, NY, OH, AND PA

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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only

# Acupuncture Professional Liability Application

## APPLICABLE IN ME, TN, VA 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 NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

## 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.

## VII. REPRESENTATIONS

***This Application must be signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application. By signing this Application, Applicant represents and warrants the following:***

- |    |   |
|----|---|
| 1. | <b><i>The statements in the Application or Renewal Application furnished to the Company are accurate and complete;</i></b>  |
| 2. | <b><i>Those statements furnished to the Company are representations Applicant makes on behalf of all proposed Insureds;</i></b>   |
| 3. | <b><i>Those representations are a material inducement to the Company to provide a premium proposal;</i></b>   |
| 4. | <b><i>If a policy is issued, the Company will have issued this Policy in reliance upon those representations;</i></b>   |
| 5. | <b><i>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</i></b> |
| 6. | <b><i>The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company.</i></b>   |

\_\_\_\_\_  
Signature of authorized representative of Applicant

\_\_\_\_\_  
Title

\_\_\_\_\_  
Type / Print name of authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-mail address of authorized representative