

National Fire & Marine Insurance Company
 Omaha, Nebraska
**MULTI-SPECIALTY HEALTHCARE PROFESSIONAL
 PROFESSIONAL LIABILITY INSURANCE APPLICATION
 NATUROPATHIC MEDICINE**

APPLICATION INSTRUCTIONS

1. Individual applicants should begin this application in Section I., General Information, Individual Applicant.
2. Entity/Group applicants should begin this application in Section I., General Information, Entity/Group Applicant.
3. If additional space is needed, use the Section IX., Supplemental Information with reference to the relevant question.
4. Print legibly. Answer all questions; if a question is not applicable, state "N/A".

I. GENERAL INFORMATION

INDIVIDUAL APPLICANT:

A. Please check all that apply:

- Sole Proprietor/Solo Incorporated
- Employed or Contracted with a Group Practice
- Joining a current Naturopathic Medicine National Fire & Marine Policy, # _____
- Other, explain: _____

B.

First Name	M.I.	Last Name	Designation
School Name			_____/_____/_____ Graduation Date
Post Graduate Internship or Residency Program Name			_____/_____/_____ Graduation Date
_____/_____/_____ Date of Birth	_____ License/Certification #	_____ Years in Practice	_____ Hours per Week
_____-_____-_____ Phone		_____ Email	_____/_____/_____ Retroactive Date (Claims-Made Coverage Only)

C. List professional associations or societies of which you are a member: _____

D. Are you trained, licensed or certified in more than one specialty?

YES NO

If yes, list specialty and license number: _____

E. Do you need coverage for an entity that you own?

YES NO

If yes, proceed to the Entity/Group Applicant Section below.
 If no, proceed to Section II., Practice Information.

ENTITY/GROUP APPLICANT:

A. Please check all that apply:

- Professional Corporation: Sole Shareholder
- Professional Corporation: Multiple Shareholders
- Partnership or Professional Association
- Limited Liability Company (LLC)/Partnership (LLP)
- Other, please explain: _____

B. Coverage Type Desired for the Entity: Please select only one.

- Shared Limit
- Separate Limit
- Additional Insured, Vicarious Liability Coverage Only

C.

Entity Name (As stated in the legal documents filed with the state.) _____

If the entity does business under any other name, list additional entity/clinic name(s), Doing Business As ("DBA"), fictitious name, etc. _____

State of Incorporation	Tax I.D. Number	_____/_____/_____ Date Entity Formed	_____/_____/_____ Entity Retroactive Date (Claims-Made Coverage Only)
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D. FOR GROUP APPLICANTS ONLY:

Primary Contact Name	Title
_____-_____-_____ Phone	_____ Email

II. PRACTICE INFORMATION

A. **Practice Location(s):** (Please list primary location first. Combined percentage for all locations must total 100% and cannot be of equal values.)

1. **Type of Facility:** Office Hospital Other: _____

_____ % of Practice _____
Name of Primary Practice Location **County**

_____ **Street Address** _____ **Suite** _____ **City** _____ **State** _____ **Zip Code**

2. **Type of Facility:** Office Hospital Other: _____

_____ % of Practice _____
Name of Practice Location **County**

_____ **Street Address** _____ **Suite** _____ **City** _____ **State** _____ **Zip Code**

3. **Type of Facility:** Office Hospital Other: _____

_____ % of Practice _____
Name of Practice Location **County**

_____ **Street Address** _____ **Suite** _____ **City** _____ **State** _____ **Zip Code**

B. **Billing and Correspondence Address:** Location # (from Question A above): _____ Other (Please enter below):

_____ **Street Address** _____ **Suite** _____ **City** _____ **State** _____ **Zip Code**

C. **Have you, your entity, or any applicant requesting coverage, or any of your employees or independent contractors:**

1. **Discontinued any procedures in the last 5 years?** YES NO

If yes, provide the following:

Discontinued Activity: _____

Applicant Name: _____ Date Discontinued: ____ / ____

2. **Obtained coverage for professional services under another professional liability policy?** YES NO

If yes, provide the practice activity or service to exclude from your NF&M coverage: _____

III. PROFESSIONAL INFORMATION

A. **Have you, your entity, any applicant requesting coverage, or any of your employees or independent contractors ever:**

1. **Been charged with, convicted of, or indicted for any act committed in violation of any law or ordinance, other than traffic offenses?** YES NO

2. **Had hospital privileges, DEA license, healthcare license or reimbursement privileges denied, refused, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?** YES NO

3. **Been accused of sexual misconduct of any kind?** YES NO

4. **Been aware of having a health condition that could impair the ability to practice their profession?** YES NO
(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics, or other controlled substances, etc.)

5. **Been cancelled, declined, non-renewed or had a prior insurance policy rescinded for any type of professional insurance; e.g., malpractice, general liability, cyber/privacy liability, and/or employment liability?** YES NO

If yes, to any questions in this section, provide the information below. If additional space is needed, use Section IX.

Explanation: _____

Applicant Name(s): _____ Date: ____ / ____

IV. ROSTER OF STAFFING

Complete this section for Entity/Group Applicants Only.

- A. Identify all owners, employees and contracted individuals who provide professional services on behalf of the Entity/Group.
 B. Provide all of the below information for each individual who is requesting coverage.
 C. For individuals who are not requesting coverage, complete Name, Status and Specialty only.

Last Name, First Name, M.I., Designation <small>(i.e. Smith, Jane G., ABC)</small>	Status: <small>Owner Employee Contractor</small>	Specialty	Coverage Needed? <small>(Yes or No)</small>	School Name	Grad Date <small>(MM/YY)</small>	Post Grad Training? <small>(Yes or No)</small>	Practice Location # and % at each	License/Cert. #	Date of Birth	Years in Practice	Patients per week	Hours per week	Membership Association	Retro Date CM only <small>(MM/DD/YY)</small>

V. NATUROPATHIC SCOPE OF PRACTICE INFORMATION

The following section should be completed for each Acupuncturist, Chiropractor, Naturopath, Nurse Practitioner or Physician Assistant applying for coverage.

A. Identify the type of procedures, treatments or specialty areas of practice that you provide to your patients:

Applicant Name: _____

Select	Treatment/Procedure/Specialty	Select
Acute Care	Intrauterine Devices (IUD) - Insertion	
Acupuncture	Intrauterine Devices (IUD) - Removal	
Addiction and Rehabilitation - Including Suboxone	Lipid Extraction	
Biopsy - Cervical or Endometrial	Lipodissolve	
Botox and Dermal Fillers	Liposuction*	
Carboxytherapy*	Medical Marijuana	
Chelation Therapy - Other	Mesotherapy	
Chelation Therapy - IV	Midwifery - Including Childbirth*	
Chemical Peels	Nutrient Therapy - Including IV	
Chiropractic	O2 Therapy	
Cold Chamber/Whole Body Cryotherapy	Obstetrics - Including Childbirth*	
Colon Hydrotherapy*	Ozone (O3) Therapy*	
Colonics*	O Shot	
Colposcopy	P Shot	
Cool Sculpting	Panchakarma*	
Dermatological Laser Treatment	Pediatrics	
Emesis and Purgation*	Platelet Rich Plasma (PRP) Therapy	
Escharotic Treatment*	Prenatal or Postnatal Care	
Fertility - Diet, Nutrition, Hormone Balancing	Prolotherapy	
Fertility - IUI, Imaging, Medication to Stimulate Egg Production	Radio Frequency Wrinkle Reduction	
Frenectomy	Radon Therapy*	
Gynecology/Well-Woman Care Visits	Rebirthing Therapy*	
Homeopathic/Holistic Medicine	Sclerotherapy	
Human Chorionic Gonadotropin (HCG) Weight Loss*	Supplements or Nutraceuticals - Sell to Patients	
Injection - Epidural and Spinal*	Supplements and Medication - Formulate Your Own	
Injection—Gas into blood vessel*	Stem Cell Therapy - Amnion-Derived or Autologous	
Injection—Silicone*	Stem Cell Therapy - Bone Marrow*	
Injection - Trigger Point	Minor Surgery - Including laceration repair & removal of lesions*	
Injection - No Opiates	Sweat Lodge Therapy*	
Injection - With Opiates	Telemedicine	
Other -	Vampire Facials	

*** Note: The following exclusions are added to the National Fire & Marine policy for which you are applying for coverage:**

- *Arising out of a wrongful act that involves, relates to, or is connected in any way with any of the following: Bone Marrow Extraction; Carboxytherapy; Emesis and Purgation; Epidural Injection; Escharotic Treatment; Gas Injection into the blood vessel; Liposuction; Intravenous Ozone Therapy; Midwifery including but not limited to childbirth; Obstetrics including but not limited to childbirth; Panchakarma including but not limited to Basti, Vamana, Virechana, Nasya and Raktamokshana; Radon Therapy; Rebirthing Therapy with physical restraints; Silicone Injection; Spinal Injection; Surgery, except the following if performed solely utilizing topical anesthetic, local anesthesia injection and/or nitrous oxide: minor laceration repair, removal of benign skin lesions, removal of foreign bodies, and minimally invasive skin and gynecological biopsies; Sweat Lodge Therapy; Diet consisting of less than 750 calories per day; or Non-prescription grade Human Chorionic Gonadotropin (HCG).*
- *Arising out of a wrongful act that involves, relates to, or is connected in any way with Colon Hydrotherapy or Colonic: (a) to a patient who has a history of, or currently has, colorectal cancer, diverticulitis or a perforated colon, (b) by an Insured who is not certified in colon hydrotherapy at the time of treatment, (c) that is rendered without an Insured first obtaining an updated medical history for the patient to whom treatment is rendered, (d) using non-disposable speculums, or (e) using non-FDA registered equipment.*

VI. LOSS INFORMATION

For the following section, include information for all types of professional liability insurance; e.g., malpractice; general liability; cyber/privacy liability; and/or employment practices liability. A **Loss Information Supplement** must be completed for each.

- A. Have you, your entity, any applicant requesting coverage, or any of your employees or independent contractors ever been:**
- 1. Involved in a claim e.g., demand for money?** YES NO
 If yes, how many? _____
 - 2. Involved in a lawsuit?** YES NO
 If yes, how many? _____
 - 3. Aware of any complication, event, incident or adverse outcome that might reasonably result in a claim or lawsuit or had a request for a patient's medical records from an attorney?** YES NO
 If yes, how many? _____

VII. COVERAGE INFORMATION

- A. Coverage Effective Date:** _____ / _____ / _____ 12:01 AM Annual policy terms will begin and end on the same month/day.
- B. Limits of Liability:** \$1,000,000 per claim / \$3,000,000 annual aggregate
- C. Coverage Type:**
- Occurrence
 - Claims Made
- Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to Claims-Made coverage or the additional expense associated with an "extension contract(s)" or "tail coverage".
- D. Prior Carrier Information:** Provide information for all professional liability insurance companies that have provided coverage for the applicant for the last 3 years. List "N/A" if there has not been coverage in the last 3 years.

Insurance Carrier	Limits of Liability	Deductible/ Retention	Policy Period (MM/DD/YY - MM/DD/YY)	Retroactive Date (MM/DD/YY)	Premium

- E. If the most recent prior coverage was issued on a Claims-Made basis and a different retroactive date, from what is on the most recent declarations page, is being requested, please select one of the following:**
- Not Applicable** — the retroactive date being requested is the same retroactive date that I have with my current carrier.
 - An extension contract endorsement (tail coverage) **has been or will be purchased.**
 - An extension contract endorsement (tail coverage) **has not and will not be purchased.** I will not purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy, for which I am applying from The National Fire & Marine Insurance Company, will not provide Prior Acts coverage.
- F. Would you like to purchase General Liability coverage (Bodily Injury/Property Damage) for an additional charge?** YES NO
If yes, are you required by contract to name an Additional Insured on your General Liability Policy? YES NO
- 1. If yes,** provide the information requested below. If you have more than one Additional Insured that is required by contract to be named on your policy, provide their name, mailing address and nature of professional relationship to you in Section IX., Supplemental Information.
 Additional Insured Name: _____
 Practice Address: _____
Street Address Suite City State Zip Code
 Nature of Professional Relationship to you:
 Lessor of Equipment – Rent or Lease Equipment – Description of Equipment: _____
 Lessor of Premises – Own, Rent or Lease Location
 Other – Explain: _____

VIII. NOTICES AND AGREEMENTS

MANDATORY: ALL APPLICANTS must read the following:

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, which may include voiding of the policy if allowed by state law.

By my signature, I hereby represent that all applicants have granted me full authority to execute this application on his, her or the entity's behalf and I am authorized to represent and sign on behalf of anyone from my practice. I also represent that I have reviewed the responses contained in this application with the applicants, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicants and that they understand and agree that such representations are binding upon him, her or the entity, even though I am executing this application on the applicants' behalf.

I further acknowledge that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "**Attachments**") for the purposes of my, or any applicants' initial or renewal application, are true and that I, nor any applicant, have not knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in professional specialty, affiliation or working arrangement with any other healthcare professional, facility, firm or professional association.

I understand that any material misrepresentation or omission made by me or any other applicant on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not, nor is any other applicant relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.

I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I or any applicant understands that if payment of premium or first installment is by check, electronic transfer or money order, it shall not be considered "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I, OR ANY APPLICANT, FAIL TO COMPLY WITH THESE TERMS WE **WILL HAVE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.**

I, or any other applicant, understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me or any applicant, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

By signing this application on behalf of a group, or an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I warrant that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

IX. ELECTRONIC SIGNATURE TERMS AND CONDITIONS

The Electronic Signature Terms and Conditions set forth below address the circumstances under which you agree to conduct business with the Company. In order to transact business electronically, your consent is needed. Please review the terms and conditions below.

By initialing in the "I understand and agree to the Electronic Signature Terms and Conditions" box below, you are signing this application for insurance electronically, thereby providing your electronic signature. You agree your electronic signature is the legal equivalent of your manual signature and that your electronic signature constitutes your acceptance and agreement as if this application was signed by you in writing. Furthermore, you consent to be legally bound by all statements made by you in this application for insurance. You also agree that no certification authority or other third party verification is necessary to validate your electronic signature and that lack of any such certification or verification will not in any way affect the enforceability of your electronic signature.

System Requirements: Electronic documents are published in Hyper Text Markup Language (HTML) or Portable Document Format (PDF). By initialing in the box below, I confirm that I can access and retain documents in HTML or PDF format. In order to participate in this program, I will need an email address, Internet access, and an Internet browser that is HTML JavaScript enabled. I will be advised if there is a change in the hardware or software requirements. The revised requirements will be described and I will be given the opportunity to withdraw my consent without charge or imposition of any conditions or consequences not described below.

Receiving Email: I may provide or update my email address at any time by calling the Company at 888-MEDPRO5 (888-633-7765).

Special Notice for Policyholders in the State of Kentucky: The policyholder who elects to allow for documents to be sent to the email address provided by the policyholder should be aware that the election operates as consent by the policyholder for the documents to be sent electronically. Therefore, the policyholder should be diligent in updating the email address provided in the event that address should change.

Requesting and Viewing Electronic Documents: Without revoking my consent, I can request a paper or an electronic copy of my application by calling the Company at 888-MEDPRO5 (888-633-7765).

Changing Selections or Revoking Consent: My consent is effective until further notice to MedPro Group. At any time, I may withdraw my consent and receive paper documents, or update my email address. Even if I consent to receive documents electronically, I may request paper documents at any time at no additional cost by calling the Company at 888-MEDPRO5 (888-633-7765). Documents will be provided to me in paper form at no additional charge. After I withdraw my consent, which may take up to ten (10) days to process, all future documents will be provided to me in paper form. Withdrawal of my consent will not affect the legal enforceability of any document, or result in the imposition of additional fees, conditions or consequences not previously described.

I understand and agree to the Electronic Signature Terms and Conditions

Initial
Here

Application must be signed by the Individual Applicant, a President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or Office Administrator or equivalent Authorized Representative on behalf of all members of the Entity/Group.

Applicant or Authorized Representative Signature/Title

Printed Name

Date Signed

Agent/Producer Name

Agent License Number

