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** **Patients 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)

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 (i.e. Smith, Jane G., ABC)	**Status:** Owner Employee Contractor	**Specialty**	**Coverage Needed?** (Yes or No)	**School Name**	**Grad Date** (MM/YY)	**Post Grad Training?** (Yes or No)	**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** (MM/DD/YY)

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 <u>exclusions</u> 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 <u>different retroactive date</u>, 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	

X. Supplemental Information

California Privacy Notice

This California Privacy Notice is provided pursuant to the California Consumer Privacy Act of 2018 (as amended by the California Privacy Rights Act of 2020) (collectively, "CCPA"). Terms defined in the CCPA have the same meaning when used in this California Privacy Notice.

Categories of Personal Information Collected

The following table lists the categories of personal information about consumers which we may collect, along with the business purpose(s) for which each category of personal information may be used.

Category of Personal Information	Business Purposes
Personal identifiers, such as full name, date of birth, government-issued identifiers such as social security number or license number	Actuarial and underwriting purposes, claims administration, marketing, policy administration, for communicating with you, to provide and manage products or services to you, employment purposes, including benefit administration and human resource management, and otherwise in furtherance of our business relationship with you
Contact information	Actuarial and underwriting purposes, claims administration, marketing, policy administration, for communicating with you, to provide services to you, employment purposes, including benefit administration and human resource management, and otherwise in furtherance of our business relationship with you
Sensitive personal information, including, but not limited to, government-issued identifiers such as social security number, driver's license number, or state identification card	Actuarial and underwriting purposes, claims administration, policy administration, and to provide and manage products or services to you
Commercial information	Actuarial and underwriting purposes
Information related to our transaction(s) with you	Policy administration, for communicating with you, to provide services to you, and otherwise in furtherance of our business relationship with you
Information regarding your interaction with our website	Actuarial and underwriting purposes, marketing, for communicating with you, and to provide services to you
Professional or employment-related information	Actuarial and underwriting purposes, claims administration, marketing, policy administration, to provide services to you, employment purposes, including benefit administration and human resource management, and otherwise in furtherance of our business relationship with you

Claims information	Actuarial and underwriting purposes, claims administration, to provide services to you, and otherwise in furtherance of our business relationship with you
Other information in the public domain	Actuarial and underwriting purposes, claims administration, marketing, policy administration, for communicating with you, to provide services to you, and otherwise in furtherance of our business relationship with you
Other information provided to us by you or on your behalf	Actuarial and underwriting purposes, claims administration, marketing, policy administration, for communicating with you, to provide services to you, employment purposes, including benefit administration and human resource management, and otherwise in furtherance of our business relationship with you

MedPro Group's privacy policy can be found at https://www.medpro.com/privacy-policy.