Renewal Effective Date: _____ **NF&M Policy Number**: _____

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

A. Name: _____ _____ _____ _____
First Name **M.I.** **Last Name** **Designation**

B. Billing and Correspondence Address: _____ _____ _____ _____
Street **City** **State** **Zip**

C. Contact Information: _____ _____
Phone Number **Email Address**

D. Since your last application with National Fire & Marine, have you made changes to:

1. The number of hours you treat patients per week? □ **Yes** □ **No**

If yes, please provide the total hours per week: _____

2. The number of patients treated per week? □ **Yes** □ **No**

If yes, please provide the total number of patients per week: _____

3. The type of procedures, treatments or specialty areas of practice that you provide to your patients? □ **Yes** □ **No**

If yes, complete the Naturopathic Medicine Modality Supplement

4. Your practice locations? □ **Yes** □ **No**

If yes, complete the Naturopathic Medicine Practice Location Supplement

5. Your professional association or society memberships? □ **Yes** □ **No**

If yes, please provide a list of active memberships:_____

E. For the following questions, only answer for items that have NOT been reported to the National Fire & Marine or that have not been previously listed on an application with National Fire & Marine.

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

If yes, please explain:_____ Date: _____

2. Have you 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**

If yes, please explain:_____ Date: _____

3. Have you been accused of sexual misconduct of any kind? □ **YES** □ **NO**

If yes, please explain:_____ Date: _____

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

If yes, please explain:_____ Date: _____

5. Have you been involved in a claim e.g., demand for money? □ **YES** □ **NO**

If yes, how many? _____ Complete a Loss Supplement for each claim.

6. Have you been involved in a lawsuit? □ **YES** □ **NO**

If yes, how many? _____ Complete a Loss Supplement for each lawsuit.

7. Are 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? _____ Complete a Loss Supplement for each incident and request for records.

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.

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	

Renewal Effective Date: _____ **NF&M Policy Number**: _____

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

A. Name: _____

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

Treatment/Procedure/Specialty	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; Cold Chamber/Whole Body Cryotherapy; 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.*

Renewal Effective Date: _____ **NF&M Policy Number**: _____

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

A. Name: _____

B. 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**

4. Type of Facility: □ Office □ Hospital □ Other: _____

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

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

C. Please provide your license state and license number for each state that you provide professional services to patients.

State:_____ **License Number:** _____

State:_____ **License Number:**_____

State:_____ **License Number:** _____

State:_____ **License Number:**_____