ACUPUNCTURISTS PROFESSIONAL AND GENERAL LIABILITY APPLICATION—CLAIMS MADE AND REPORTED BASIS

Please email this completed application to the IGP Specialty underwriter you are working with.
For contact information, please visit our Healthcare Program webpage.

1. APPLICANT INFORMATION

a. Complete name of applicant facility (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

Address: _____

City: _____ State: _____ County: _____ ZIP: _____

Contact Name: _____ Title: _____

Contact Email Address: _____ Phone: _____

Website URL: _____

List all other locations:

b. Professional degree: _____

c. Place of birth: _____

d. Applicant is (check all that apply):

- ☐ U.S. citizen—if not, status: _____
- ☐ Self-employed individual (incorporated)
- ☐ Self-employed individual (unincorporated)
- ☐ Partnership
- ☐ Employee of (name of employer): _____
- ☐ Other (describe): _____
- ☐ Professional association
- ☐ Professional corporation (for profit)
- ☐ Professional corporation (non-profit)

e. In addition to acupuncture, do you have other professional specialties? Please describe below:

f. Date established: _____

g. Please state sources and amounts of total gross annual revenue:

Source of revenue	Amount last 12 months	Amount next 12 months
	$	$
	$	$
	$	$

h. If you practice **other than as an employee** OR an **unincorporated** solo practitioner, specify:

i. Formal business, corporate or partnership name: _____

ii. List the names of all partners or members of your professional association/corporation who provide professional services:

Attach a copy of your letterhead.

i. Are you associated with or do you work for a physician or surgeon? ☐ Yes ☐ No
If yes, physician name and specialty: _____

j. Are you employed by an individual other than that shown in Question 1 above? ☐ Yes ☐ No
If yes, please attach an explanation, including details of your responsibilities.

k. Are you under contract to any individual or entity other than that shown in Question 1above? ☐ Yes ☐ No
If yes, please attach an explanation, including details of your responsibilities. If this contract contains a hold-harmless agreement, please attach a copy of the contract.

l. Are you employed by or under contract to any governmental entity? ☐ Yes ☐ No
If yes, please attach an explanation, including details of your responsibilities.

m. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No
If yes, has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No
Name and title of the applicant's Privacy Officer: _____

n. Provide the following information for all of the states in which you practice:

State	License Number	Effective Date	Expiration Date	Active?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If none, please attach an explanation.

o. Are you licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
If no, please attach an explanation.

p. Does your state license or register acupuncturists? ☐ Yes ☐ No
If yes, license number: _____ Expiration date: _____

q. Are you NCCA certified? ☐ Yes ☐ No
If yes, please provide certificate information:
Date of Certification: _____ Certificate number: _____ Expiration date: _____

r. Are you currently in active military service? ☐ Yes ☐ No

s. Describe professional training including formal classroom education, tutorials, seminars, etc., **or** attach a current resume:

2. EDUCATION

Describe your professional training:

Institution Name and Address	Years of Training		Degree or Certification Attained
	From:	To:	
	From:	To:	
	From:	To:	
	From:	To:	

3. PRIOR EXPERIENCE

Where have you practiced your profession during the last ten years?

a. From: _____ To: _____ Location: _____
Practice activity: _____

b. From: _____ To: _____ Location: _____
Practice activity: _____

c. From: _____ To: _____ Location: _____
Practice activity: _____

d. Have you ever failed any professional licensing or specialty organization examination? ☐ Yes ☐ No
If yes, please attach a detailed explanation, including dates and location.

4. YOUR PRACTICE

a. Approximate percentages of time spent in the following work locations:

_____ % Administrative office
_____ % Classroom
_____ % Nursing home/assisted living
_____ % Professional office (specify profession): _____
_____ % Other (specify): _____
_____ % Outpatient clinic
_____ % Patient's home

b. Please indicate the approximate division of your patients or clients among:

_____ % Holistic medicine
_____ % Research or experimental
_____ % Drug addicts
_____ % Physician rehab
_____ % Disability evaluation (describe): _____
_____ % Pain Management (describe): _____
_____ % Obstetrical
_____ % Dental
_____ % Pediatric
_____ % Psychiatric

Must total 100%.

c. Do you render professional services directly to patients? ☐ Yes ☐ No
If yes, please describe these services in detail and indicate whether you are supervised and by whom.

Detailed Description of Professional Services	Percent of time Supervised	Qualifications of Supervisor
	%	
	%	
	%	

d. Do you render professional services that do not involve contact with a patient? ☐ Yes ☐ No
If yes, please describe these services in detail.

e. List the number of your employees and volunteers (if none, state "none"):

Type of employees/volunteers	Number

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i. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No

ii. Do you supervise any individuals other than your own employees? ☐ Yes ☐ No

If yes, give detailed explanation of responsibilities and relationships to the entity which employs these individuals.

Indicate by professions the number of individuals supervised:

Type of profession: _____ Number: _____

f. Provide number of patient or client encounters:

Type of visit	Number of visits last 12 months	Number of visits next 12 months
Clinic		
Office		
Other		
Total number of visits		

g. Do you administer any anesthesia? ☐ Yes ☐ No

If yes, please explain and indicate whether you are supervised and by whom:

h. Do you:

i. Use the National Council on Certification of Acupuncturists (NCCA) clean-needle technique? ☐ Yes ☐ No

If no, do you use disposable needles? ☐ Yes ☐ No **If no,** please attach details.

ii. Dispense or prescribe drugs? ☐ Yes ☐ No

iii. Use x-ray or imaging in treatment determination? ☐ Yes ☐ No

iv. Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? ☐ Yes ☐ No

v. Perform investigational or experimental research or therapy on human patients? ☐ Yes ☐ No

i. Do you compound in bulk, manufacture, wholesale oriental/herbal medicine or other nutritional substances or controlled substances? ☐ Yes ☐ No

If yes, please provide details:

j. Do you prescribe or dispense any drugs without the countersignature of a physician? ☐ Yes ☐ No

If yes, please provide a detailed explanation.

k. i. Do you perform or assist in any surgical procedure(s)? ☐ Yes ☐ No

If yes, please answer **ii** below.

ii. List **all** surgical procedures performed (including minor surgery):

iii. Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ☐ Yes ☐ No

If yes, please attach a detailed explanation.

iv. Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? ☐ Yes ☐ No

If yes, please attach a detailed explanation.

l. i. Do you perform radiation therapy? ☐ Yes ☐ No
ii. Psychiatric shock therapy? ☐ Yes ☐ No

5. APPLICANT HISTORY

Attach a detailed explanation for any "yes" answers.

Have you:

a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ☐ Yes ☐ No
b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
c. Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ☐ Yes ☐ No
e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

6. EXISTING INSURANCE

Do you currently carry the following:

a. Professional Liability Insurance? ☐ Yes ☐ No

If yes, list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

If claims made, what is the retroactive date/prior acts date on your current policy? _____

b. Commercial General Liability Insurance? ☐ Yes ☐ No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

If claims made, what is the retroactive date/prior acts date on your current policy? _____

7. CLAIMS HISTORY

a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.
IF NO PRIOR COVERAGE, COMPLETE CLAIM SUPPLEMENT.

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No
If yes, provide full details:

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
☐ Yes ☐ No
If yes, fully describe the circumstances and follow up action taken:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Notice applicable in most states: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____

