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Glastonbury, CT 06033
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Chiropractic Professional Liability Application

This application will be incorporated into the policy if coverage is bound. All questions must be answered accurately and completely. Please call your insurance representative if you have any questions.

Instructions:

- A. Please print or type text directly into the application (PDF Format).
- B. Answer all questions leaving no blanks.
- C. Check all boxes that apply. If any questions, or part thereof, do not apply, state N/A in the space.
- D. If Space is insufficient to answer any question fully, attach a separate sheet of paper.
- E. This application must be completed, dated, and signed by the applicant.
- F. Include copies of loss runs for the past 10 years (or back to retroactive date, whichever is longer), dated within the last 90 days. Provide complete details for any losses paid. Do not indicate patient identifiers or any personal identifiable health information.
- G. Attach copy of your curriculum vitae.
- H. Attach a copy of your medical license.
- I. Attach a copy of your Declaration Page from your current policy.

I. APPLICANTS PERSONAL INFORMATION

Name of Applicant:

First: _____ Last Name: _____ Middle Initial: _____

DOB: _____ Gender: ☐ M ☐ F

Home Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Email: _____

Mailing Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Office Address:

Employer/Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Office Manager: _____

Email: _____

Billing Address (if different than Mailing address):

Address: _____

City: _____ State: _____ Zip Code: _____

II. COVERAGE INFORMATION

Desired Effective Date: _____

Desired Retroactive Date: _____

☐ Board Certified ☐ Board Eligible ☐ Other

Date of Certification: _____

Date of Recertification: _____

NPI #: _____

Medical License #: _____ Expiration Date: _____

DEA License #: _____

Controlled Substance #: _____

Medical Specialty: _____

Sub-Specialty: _____

Name of Specialty Board: _____

1. Have you ever applied to Integris Insurance Company in the past? ☐ Yes ☐ No

2. How many hours per week do you practice? _____
3. Do you have a position for which no coverage is required under the Integris Insurance Company policy or which you are already otherwise insured? ☐ Yes ☐ No
If Yes, provide the name of the hospital or other institution that provides the coverage and initial employment date.
Hospital/Institution: _____ Initial Employment Date: _____
4. Names of business(es) which you own or for whom you work - include names under which you are doing business (DBA)
Name: _____ Location: _____
Name: _____ Location: _____
5. Do you practice out-of-state or interpret films or tests of patients from out-of-state? ☐ Yes ☐ No
If Yes, where? _____
a. How many hours per week do you practice out-of-state? _____
b. Percentage of your total practices out-of-state? _____
c. How many patients per week do you see out-of-state? _____
6. Coverage: ☐ Occurrence ☐ Claims Made
7. Answer only if the previous policy was Claims Made or if you are requesting a Claims Made policy:
a. Do you have prior acts coverage? ☐ Yes ☐ No
b. What is the retroactive date on your current Claims Made policy? _____
8. Attach copies of your continuing education course certifications.
9. Limits of Liability (please click on the limits that apply to your practice)
☐ **Connecticut Limits**
☐ \$500,000/\$1,500,000 ☐ \$1,000,000/\$3,000,000 ☐ \$1,000,000/\$4,000,000
☐ **Massachusetts Limits**
☐ \$1,000,000/\$2,000,000 ☐ \$1,000,000/\$3,000,000 ☐ \$2,000,000/\$6,000,000

III. CURRENT PRACTICE INFORMATION

1. Do you practice as a:
☐ Solo practitioner ☐ Employed chiropractor without ownership interest in employer's practice
☐ Partner in a partnership ☐ Independent contractor in office of another DC
☐ Shareholder in a Professional Corporation (PC) ☐ Other: _____ (Please state)
Attach copies of incorporation papers
2. If you are in a partnership or corporation, do you want the partnership/corporation to be covered under your malpractice policy? ☐ Yes ☐ No
If "Yes": ☐ w/shared limits (no additional premium) ☐ w/separate limits
a. Name of the partnership/corporation: _____
b. Federal ID #: _____
3. List all names of chiropractors in the partnership/corporation, with whom they are insured, and the limits of liability provided:
- | Name: | Insurance Carrier: | Limits of Liability: | Expiration Date: |
|-------|--------------------|----------------------|------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
4. List all other licensed/registered professionals employed by the partnership/corporation:

Name:	Insurance Carrier:	Limits of Liability:	Expiration Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Other Practice Locations

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

IV. EDUCATION INFORMATION

1. Chiropractic College Attended (Name): _____ State: _____

Graduation Date: _____ Degree Earned: _____ Original License Date: _____

2. State(s) Licensed:

State:	License #:	License Date:	Expiration Date:
_____	_____	_____	_____
_____	_____	_____	_____

3. Name all the places where you have practiced (excluding residency or fellowship)

_____	From: _____	To: _____
_____	From: _____	To: _____

4. Name of entities to receive Certificate(s) of Insurance:

Name:	Address:
_____	_____
_____	_____

V. EMERGENCY BACKUP

- | | | |
|--|------------------------------|-----------------------------|
| 1. Are your staff members trained in first aid procedures? | ☐ Yes | ☐ No |
| 2. Are procedures in place to provide aid to injured parties in the event of an emergency? | ☐ Yes | ☐ No |
| 3. Do you have arrangements in place with emergency medical facilities? | ☐ Yes | ☐ No |
| 4. Is your office within 10 miles from a hospital, clinic, or other medical facility? | ☐ Yes | ☐ No |

VI. PRACTICE INFORMATION

(If yes, to questions A through I, please provide additional information including loss estimates or payment amounts on a separate sheet. Please sign and date the information)

- | | | |
|---|------------------------------|-----------------------------|
| A. Have you ever been convicted of, pleaded guilty or no contest to, any violation of a law or ordinance other than minor traffic offenses? | ☐ Yes | ☐ No |
| B. Have you ever been treated for alcoholism or drug addiction? | ☐ Yes | ☐ No |
| C. Do you now or have you ever had any chronic physical defect or any mental or emotional illness or disorder, which impaired or could adversely affect your ability to practice chiropractic medicine to any degree? | ☐ Yes | ☐ No |
| D. Have you ever signed a consent order or consent agreement with, or been investigated by, a state health department, state licensing board or other governmental body? | ☐ Yes | ☐ No |
| E. Have you ever practiced without malpractice insurance or had it canceled, non-renewed, denied or offered to you only on special or restricted terms? | ☐ Yes | ☐ No |
| F. Has your license to practice ever been revoked, suspended or subjected to probation? | ☐ Yes | ☐ No |
| G. Do you have a relationship with a radiologist who over reads your x-rays? | ☐ Yes | ☐ No |

H.	Do you perform Manipulation Under Anesthesia (MUA)? Note: Coverage will not be provided for MUA.	☐ Yes	☐ No
I.	Do you desire coverage for needle acupuncture?	☐ Yes	☐ No
	If "Yes": a. Do you currently perform acupuncture?	☐ Yes	☐ No
	b. Where did you receive your training in acupuncture? (Name of city) _____		
	c. Attach a copy of specialty degree of competence and state certification(s) issued to you.		
	Note: Approval is required before coverage will be effective.		
VII. CLAIMS INFORMATION			
<i>Please note that the use of claim or suit in this application is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any professional corporation</i>			
1.	Are you or have you been involved in a malpractice claim or suit, either directly or indirectly? If yes, please indicate total number of claims and suits: ____Open ____Closed A Claim Addendum may be requested for open claims or suits.	☐ Yes	☐ No
2.	Have all claims and suits been reported to your current or prior professional liability carrier?	☐ Yes	☐ No ☐ N/A
3.	Are you aware of any of the following circumstances regarding medical care you provided:		
A.	A letter or request for records from a patient or a patient's attorney or representative related to an adverse outcome from care you provided to a patient?	☐ Yes	☐ No
B.	A statement by or letter from a patient or patient's representative expressing dissatisfaction or questioning the quality or timeliness of any care you provided to a patient?	☐ Yes	☐ No
C.	A statement by or letter from a patient or patient's representative claiming a failure to provide care on your part or failure to diagnose?	☐ Yes	☐ No
D.	Intra- or post-procedural complications or other treatment complications resulting in death, paralysis, loss of body part or bodily function, disability, re-operation or extended hospitalization or other morbidity?	☐ Yes	☐ No
E.	Any death (expected or otherwise), neurological, sensory, or systematic deficits of a patient including but not limited to brain damage, permanent paralysis, loss of sight or hearing, loss of limb, or other morbidity from care you provided whether or not you believe that medical standards of care were met?	☐ Yes	☐ No
F.	Any permanent damage related to an injury during delivery of child or administration of anesthesia?	☐ Yes	☐ No
G.	Has a patient, patient's representative or representative filed any complaint or grievance to any healthcare institution, institution at which you practice and/or managed care organization of which you are a member, regarding care you provided to a patient?	☐ Yes	☐ No
H.	Has a patient, patient's representative or any healthcare institution filed any governmental report (including Department of Public Health, and other state or federal agency) or grievance regarding care you provided to a patient?	☐ Yes	☐ No
I.	Has your care ever been the subject of a peer review, sentinel event report or other investigation by any healthcare institution?	☐ Yes	☐ No
J.	Are you aware of any expression of dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you whether from a patient or a patient's family or representative?	☐ Yes	☐ No
K.	Have all circumstances that might reasonably lead to a medical incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	☐ Yes ☐ No ☐ None to Report	
VIII. ASSIGNMENT OF POLICY RIGHTS			
I assign to my employer or professional entity the right to cancel my policy and/or change my coverage terms and to receive any unearned premium due to policy changes for which my employer has paid the premium (e.g. termination of coverage, limit decrease, etc.).			
This may be revoked by me at any future time by sending written notice to Integris Insurance Company.			_____ Initials

IX. WARRANTY: PRIOR KNOWLEDGE OF FACTS/ CIRCUMSTANCES/SITUATIONS

For Alaska, Florida, Georgia, Kansas, Kentucky, Maine, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Virginia, Washington, and West Virginia residents ONLY: the title of this section and any other reference to "WARRANTY" is deleted and replaced with "Applicant Representation."

No person or entity proposed for coverage is aware of any fact, circumstance or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage: NONE, or except

Without prejudice to any other rights and remedies of the Company, the Applicant understands and agrees that if any such fact, circumstance or situation exists, whether or not disclosed in response to this section, any claim or action based on, arising from, or in consequence of such fact, circumstance, or situation is excluded from coverage under the proposed policy, if issued by the Company.

X. DISCLOSURE AUTHORIZATION

I AUTHORIZE the release and exchange of information regarding my insurance coverage and any changes thereto between the Company and any and all hospitals where I have privileges or any other institution to which the Company provides a Certificate of Insurance for the purpose of confirming my coverage (including their employees, officers, agents, directors and other representatives). This authorization does not create any obligation for the Company to release or exchange such information.

I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made by me herein (and their employees, officers, agents, directors and other representatives) to release such information to the Company and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues.

I AUTHORIZE the Company and such representatives to use a copy of this authorization in place of the original. This authorization shall be valid for one year from the date signed. I understand that upon request, I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization.

XI. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES

The Applicant's submission of this Application does not obligate the Company to issue, or the Applicant to purchase, a policy. The Applicant will be advised if the Application for coverage is accepted. The Applicant hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the insurance policy should a policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such policy; and that the Company will have relied on all such materials in issuing any such policy.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.

Notice to Alabama and Maryland Applicants: 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 and may be subject to fines and confinement in prison.

Notice to Arkansas, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to Colorado Applicants: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: 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.

Notice to Kentucky Applicants: 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.

Notice to Louisiana and Rhode Island Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maine, Tennessee, Virginia and Washington Applicants: 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 or a denial of insurance benefits.

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

Notice to Oklahoma Applicants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania Applicants: 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.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to New York Applicants: 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 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.

Please read the following carefully, and initial below.

I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. I AGREE to notify Integris Insurance Company (the "Company") promptly of any material changes in the information I have provided herein. I UNDERSTAND that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

Initials

Signature of Applicant:

Print Name: _____ Title: _____ Date: _____

Signature: _____

Signature of Broker or Authorized Representative:

Print Name: _____ License #: _____ Date: _____

Signature: _____ Company: _____

Instructions for using editable Applications and Important Legal Information:

1. Save the document to your local computer.
2. Complete the application by providing your responses in the areas provided; utilize the tab key to move ahead to the next field.
3. If there is not enough space for any particular question, please include the full response in an additional attachment to your application, as you would if you were completing a paper-based application.
4. When you have completed the application, please verify the application for accuracy and completeness before signing the application and forwarding the application to your agent or broker. Do not forward applications directly to Integris Insurance Company unless you are an agent or broker.
5. If you choose to sign the application with a wet signature, please print the final application, sign the application in ink and forward the application to your agent or broker with any necessary supporting materials.
6. If you apply your signature to this form electronically, you hereby consent and agree that your use of a key pad, mouse or other device to click the "I Agree" button constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand. Further, you agree that the lack of a certification authority or other third party verification will not in any way affect the validity or enforceability of your signature or any resulting contract. You can apply your signature electronically by clicking on the signature field. Once all signatures have been applied, forward the application to your agent or broker via email. Any necessary supporting materials should be sent via email or postal service to your agent or broker.

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Insured's Name: _____

Date: _____

Insured's Signature: _____