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**APPLICATION FOR
ACUPUNCTURISTS
PROFESSIONAL LIABILITY
INSURANCE**

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.
(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Name of Applicant (include professional degree if applicant is individual): _____

b. Business Phone: () _____ Home Phone: () _____

c. Applicant's Date and Place of Birth or Date Established: _____

d. Principal Business Address: (Attach list of any additional locations)

e. Square feet of total office space (all locations): _____

f. Applicant is:

U.S. Citizen

Self-employed Individual
(unincorporated)

Self-employed Individual
(incorporated)

Partnership

Professional Association

Professional Corporation
(for profit)

Professional Corporation
(non-profit)

Employee of _____
(give name of employer)

Other
(Describe) _____

g. Is coverage desired for the Corp./PA/Partnership? Yes No

h. The business, corporate or partnership name is: _____

i. Please give names of all partners or members of the firm who provide professional services: _____

j. Please attach a copy of letterhead or other business stationery.

2. PROFESSIONAL INFORMATION

a. Does your state license or register acupuncturists? Yes No. Applicant's license number _____

Expiration Date: Mo _____ /Day _____ /Yr _____

b. Are you NCCA certified? Yes No

If yes, please provide date of certification, certificate number, expiration date of certificate:

Date of Certification: Mo _____ /Day _____ /Yr _____ Certificate # _____

Expiration Date: Mo _____ /Day _____ /Yr _____

2. PROFESSIONAL INFORMATION (CONTD.)

c. Are you a member of AAAOM? Yes No. Current Member No. _____

d. Please describe Professional training including formal classroom education, tutorials, seminars, etc., on attached sheet, or attach a current curriculum vitae (C.V.).

e. Please indicate your professional specialty:

- | | | |
|----------------------------------------------------------|----------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Acupuncture & Oriental Medicine | <input type="checkbox"/> Naprapath | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Nurse, Licensed Practical | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Counselor (Describe) _____ | <input type="checkbox"/> Nurse, Registered | <input type="checkbox"/> Speech Therapist |
| | <input type="checkbox"/> Nurses Registry | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Visiting Nurse Assoc. |
| <input type="checkbox"/> Hearing Aid Fitter | <input type="checkbox"/> Optician | <input type="checkbox"/> X-ray Technician |
| <input type="checkbox"/> Home Health Care Agency | <input type="checkbox"/> Orthotist | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Inhalation Therapist | <input type="checkbox"/> Perfusionist | |
| <input type="checkbox"/> Laboratory Technician | <input type="checkbox"/> Pharmacist | |
| <input type="checkbox"/> Medical Personnel Pool | <input type="checkbox"/> Physical Therapist | |

f. Please indicate professional societies or association in which you are a member: _____

3. OPERATIONS	4. PERSONNEL
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a. Please indicate percentage of time spent in the following work locations:

____% Administrative Office	____% Classroom
____% Nursing Home	____% Outpatient Clinic
____% Outpatient Clinic	____% Patient Home
____% Professional Office (specify profession) _____	
____% Other (specify) _____	

a. List the number of you employees and volunteers. IF NONE, STATE NONE.

Number	Type of Employees/Volunteers
_____	_____
_____	_____
_____	_____

b. State approximate division of your patients or clients among:

(a) Holistic Medicine (____%)	(h) Physician Rehabilitation (____%)
(b) Psychiatric (____%)	(i) Disability Evaluation (____%)
(c) Drug Addicts (____%)	(j) Research or Experimental (____%)
(d) Alcoholics (____%)	(k) _____ (____%)
(e) Obstetrical (____%)	(l) _____ (____%)
(f) Dental (____%)	(m) _____ (____%)
(g) Pediatric (____%)	(n) _____ (____%)

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

If no, please attach explanation.

c. Please state sources and amounts of total annual revenue:

Source of Revenue	Amount Last 12 Months	Amount Next 12 Months
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

Also indicate by profession the number of individuals supervised.

Number	Type of Professional
_____	_____
_____	_____
_____	_____

4. PERSONNEL (CONTD.)

d. Please provide number of patient or client encounters:

Type of Visit	Number of Visits Last 12 months	Number of Visit Next 12 Months
Clinic	_____	_____
Office	_____	_____
Other _____	_____	_____
Total Number of Visits	_____	_____

5. SERVICES

a. Do you render professional services directly to patients? [] Yes [] No.

If yes, please described in detail these services and indicate extent of supervision by others.

<u>Description of Professional Services</u>	<u>Percent of Time Supervised</u>	<u>Qualifications of Supervisor</u>
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____

b. Do you render professional services that do not involve contact with a patient? [] Yes [] No.

If yes, please describe in detail these services.

c. Do you perform or assist in any surgical procedures? [] Yes [] No

(i) Please list ALL surgical procedures performed (including minor surgery).

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

If yes, please attach detailed explanation.

(iii) 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 detailed explanation.

6. PROCEDURES

a. Do you prescribe or dispense any drugs without the countersignature of a physician? [] Yes [] No
If yes, please provide detailed explanation.

b. Do you compound in bulk, manufacture wholesale oriental/herbal medicine or other nutritional substances or controlled substances? [] Yes [] No
If yes, please provide details.

c. Do you adhere to NCCA clean needle techniques? [] Yes [] No

Have you passed NCCA clean needle training course? [] Yes [] No

If yes, date passed: Mo_____/Day_____/Yr_____0

7. BUSINESS ASSOCIATIONS	
<p>a. Are you associated with or work for a physician or surgeon? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please give name and specialty of physician.</p>	<p>f. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please attach a copy of ALL of its advertisements.</p>
<p>b. Do you own or operate any business other than that shown in Question 1(a) above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please give details on a separate sheet.</p>	<p>g. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please attach detailed explanation and a copy of ALL of the advertisements.</p>
<p>c. Are you employed by an individual other than that shown in Question 1(a) above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please attach explanation, including details of your responsibilities.</p>	
<p>d. Are you under contract to any individual or entity other than that shown in Question 1(a) above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please attach explanation, including details of your responsibilities.</p> <p>If this contract contains a hold-harmless agreement, please attach copy of contract.</p>	<p>h. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please give details, including name, location, size and number of beds.</p>
<p>e. Are you in the employ of, or under contract to any governmental entity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, attach explanation, including details of your responsibilities.</p>	<p>i. (i) Do you use a collection agency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of agency _____</p> <p>(ii) Has the agency authority to file a collection suit at its discretion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

8. APPLICANT HISTORY		
<p>a. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:</p>		
<p>Have you or any of your employees...</p>	<u>YES</u>	<u>NO</u>
<p>(i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or government agency, hospital or professional association?</p>	[]	[]
<p>(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?</p>	[]	[]
<p>(iii) Ever been treated for alcoholism or drug addiction?</p>	[]	[]
<p>(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refusal or accepted only on special terms or ever voluntarily surrendered same?</p>	[]	[]
<p>(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?</p>	[]	[]
<p>b. Has any claim or suit been brought against you and/or any of your employees? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, a supplemental claim information form must be completed for each claim or suit.</p>		

c. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? [] Yes [] No

If yes, please give details on separate sheet.

8. APPLICANT HISTORY (CONTD.)

d. List prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?	
								Yes	No
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]
_____	_____	_____	_____	_____	_____	_____	_____	[]	[]

e. If prior professional liability insurance was on a claims made basis, advise the retroactive exclusion date of the coverage _____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.