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**APPLICATION FOR  
CHIROPRACTORS  
PROFESSIONAL LIABILITY  
INSURANCE**

**(Claims Made and Reported 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. A separate Application must be completed, signed and dated by each Chiropractor.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.  
(PLEASE TYPE OR PRINT IN INK)

**1. APPLICANT INFORMATION**

a. Full name of applicant and Degree designation(s):

b. Principal Office Address:

(Please attach list of additional office addresses)

c. Telephone Number: Home ( ) \_\_\_\_\_ Office( ) \_\_\_\_\_  
( ) \_\_\_\_\_ ( ) \_\_\_\_\_

d. Personal Information: (i) \_\_\_\_\_ (ii) \_\_\_\_\_ (iii) \_\_\_\_\_  
Social Security No. Birth Date MM/DD/YR Requested Effective Date

e. License Information: (i) Chiropractic License Number(s) \_\_\_\_\_  
(ii) State(s) Licensed \_\_\_\_\_  
(iii) License Expiration Date \_\_\_\_\_  
(iv) Are you licensed to practice any other health care practices? [ ] Yes [ ] No.  
If yes, please circle: MD DO DPM ND RN RPT LAC MIDWIFE  
Other: \_\_\_\_\_

f. Education: (i) \_\_\_\_\_ (ii) \_\_\_\_\_  
Chiropractor College or University, City, State, County Year of Graduation

g. Requested Limits of Liability (Limits in policy will govern coverage).

- |  |  |
|--|--|
| <input type="checkbox"/> \$100,000 per claim; \$300,000 annual aggregate | <input type="checkbox"/> \$500,000 per claim; \$1,000,000 annual aggregate   |
| <input type="checkbox"/> \$200,000 per claim; \$600,000 annual aggregate | <input type="checkbox"/> \$1,000,000 per claim; \$1,000,000 annual aggregate |
| <input type="checkbox"/> \$250,000 per claim; \$750,000 annual aggregate | <input type="checkbox"/> \$1,000,000 per claim; \$3,000,000 annual aggregate |
| <input type="checkbox"/> \$500,000 per claim; \$500,000 annual aggregate |  |

**2. APPLICANT PRACTICE**

a. Where have you practiced your profession since graduation?

- (i) In \_\_\_\_\_ State (ii) In \_\_\_\_\_ State  
(iii) In \_\_\_\_\_ State (iv) In \_\_\_\_\_ State

**2. APPLICANT PRACTICE (CONTD.)**

b. Please check one box describing your practice and fill in the blanks using an attached sheet, if necessary.

(i)  Sole proprietorship (unincorporated) \_\_\_\_\_  
Business Name

(ii)  Professional corporation \_\_\_\_\_  
Corporate Name  
 Do you want corporate coverage?  Yes  No.

(iii) Partnership \_\_\_\_\_  
Partners' Names Partnership Names

(iv) Employee, associate or independent contractor with \_\_\_\_\_  
Employer's Name

c. Please tell us how many

(i) Hours per week you practice chiropractic: \_\_\_\_\_

(ii) Patient visits you handle annually: \_\_\_\_\_

d. Approximate gross annual income from your practice

Less than \$50,000                       \$100,000 - \$149,999                       \$200,000 or more  
 \$50,000 to \$99,999                       \$150,000 - \$199,999

e. Do you anticipate any changes in your practice in the next 12 months?  Yes  No  
 If yes, please attach details.

**3. PROCEDURES**

a. Please indicate those procedures or devices used in your practice:

|                               | <u>Yes</u> | <u>No</u> |                             | <u>Yes</u> | <u>No</u> |   | <u>Yes</u> | <u>No</u> |
|-------------------------------|------------|-----------|-----------------------------|------------|-----------|---|------------|-----------|
| (i) General merric adjusting  | [ ]        | [ ]       | (xi) Cold laser             | [ ]        | [ ]       | (xxi) Stressology                       | [ ]        | [ ]       |
| (ii) Upper cervical specific  | [ ]        | [ ]       | (xii) Activator             | [ ]        | [ ]       | (xxii) Internal coccyx adjustment       | [ ]        | [ ]       |
| (iii) Instrumental adjusting  | [ ]        | [ ]       | (xiii) Galvanic             | [ ]        | [ ]       | (xxiii) Gemstone therapy                | [ ]        | [ ]       |
| (iv) Gonstead/diversified     | [ ]        | [ ]       | (xiv) Ultraviolet           | [ ]        | [ ]       | (xxiv) Toftness device                  | [ ]        | [ ]       |
| (v) Direct non-force          | [ ]        | [ ]       | (xv) Ultrasound             | [ ]        | [ ]       | (xxv) Colonic irrigations               | [ ]        | [ ]       |
| (vi) Sacro-occipital          | [ ]        | [ ]       | (xvi) Massages              | [ ]        | [ ]       | (xxvi) Treat cancer                     | [ ]        | [ ]       |
| (vii) Hydroculator/heat packs | [ ]        | [ ]       | (xvii) Short wave diathermy | [ ]        | [ ]       | (xxvii) Treat epilepsy                  | [ ]        | [ ]       |
| (viii) Electrical stimulation | [ ]        | [ ]       | (xviii) Kinesiology         | [ ]        | [ ]       | (xxviii) Manipulation under anesthesia  | [ ]        | [ ]       |
| (ix) Ice-cryotherapy          | [ ]        | [ ]       | (xix) Mechanical traction   | [ ]        | [ ]       | (xxx) Prenatal care & normal deliveries | [ ]        | [ ]       |
| (x) Trigger point             | [ ]        | [ ]       | (xx) Whirlpool              | [ ]        | [ ]       |   | [ ]        | [ ]       |

b. If the answer to any of the questions below is NO, please attach details. Do you: Yes   No

(i) Use the Georges test, the Vertebral Artery Ischemia Test or the Cerebrovascular Craniocervical Function Test when initially seeing a patient or when seeing a patient you have not seen for six months? [ ]   [ ]

**IF NO**, please describe how you assess vascular flow.

If an unusual finding results, do you refer the patient to the appropriate medical practitioner? [ ]   [ ]

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b. (i) Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)?  Yes  No

(ii) Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients?  Yes  No

If yes, please attach details and submit copy of ALL advertisements.

presented by the year 2000, including the date upon which you anticipate the problem will be solved.

(iii) Are you, in the course of your business, involved in working to solve the year 2000 problem as a consultant/advisor or as part of your employment?  Yes  No

(iv) If YES, what percentage of your work is involved?

**5. STAFF**

a. Please indicate the number of professional employees, volunteers and independent contractors (IF NONE, STATE NONE).

|                                  | No. of<br>Employees<br>and<br>Volunteer | No. of<br>Independent<br>Contractors |                             | No. of<br>Employees<br>and<br>Volunteers | No. of<br>Independent<br>Contractors |
|----------------------------------|---|--------------------------------------|-----------------------------|--|--------------------------------------|
| (i) Chiropractor                 | _____                                   | _____                                | (vii) Laboratory Technician | _____                                    | _____                                |
| (ii) Chiropractor Assistant      | _____                                   | _____                                | (viii) Physical Therapist   | _____                                    | _____                                |
| (iii) Nurses, Licensed Practical | _____                                   | _____                                | (ix) Massage Therapist      | _____                                    | _____                                |
| (iv) Nurses, Practitioner        | _____                                   | _____                                | (x) Student /preceptors     | _____                                    | _____                                |
| (v) Nurses, Registered           | _____                                   | _____                                | (xi) Other_____             | _____                                    | _____                                |
| (vi) X-ray Technician            | _____                                   | _____                                |                             | _____                                    | _____                                |

NOTE: If you require any of the above to be Named Insureds, please submit separate application for each individual.

b. Are all the above individuals licensed in accordance with applicable state and federal regulations? [ ] Yes [ ] No  
If NO, please attach explanation.

c. Are you engaged in any business other than the practice of chiropractic? [ ] Yes [ ] No  
If YES, please attach details.

d. Do you own (wholly or in part), operate or administer any hospital, nursing home, surgi-center, clinic or other facility where healthcare services are customarily rendered? [ ] Yes [ ] No  
If YES, please attach details.

e. Do you or the entity named in Question 2(b) contract to provide professional services to any individual, entity or governmental entity? [ ] Yes [ ] No  
If YES, please attach details.

f. Are you affiliated with any hospitals? [ ] Yes [ ] No  
If YES, please provide name(s), city, state.

g. Please list any professional societies/organizations in which you are currently a member:

**6. APPLICANT HISTORY/CLAIMS**

| a. Have you or any of your employees: ( <b>Attach detailed explanation for any "yes" answers</b> )   | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| (i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a government or administrative agency, hospital or professional association? (Attach copy of Complaint and Consent Order documents, if applicable.)   | [ ]        | [ ]       |
| (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  | [ ]        | [ ]       |
| (iii) Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any has any administrative agency, hospital or professional association requested or required evaluation an alleged mental condition and/or alcohol or drug addiction? | [ ]        | [ ]       |
| (iv) Ever had any state professional license refused, suspended, revoked, renewal refusal or accepted only on special terms or ever voluntarily surrendered same?  | [ ]        | [ ]       |

**6. APPLICANT HISTORY/CLAIMS (CONTD.)**

- a. Have you or any of your employees: **(Attach detailed explanation for any Ayes@ answers)** YES NO
- (v) Ever had any professional liability insurance canceled, declined, renewal refused or accepted only on special terms? [ ] [ ]
- (vi) Ever failed any professional licensing examination? [ ] [ ]
- (vii) Any chronic physical illness or defect? [ ] [ ]

b. Has any claim or suit been brought against you and/or any of your employees? [ ] [ ]

If yes, please complete a Supplemental Claim Form for each claim or suit.

c. Are you aware of any circumstances which may result in a malpractice claim or suit against you or any of your employees? [ ] [ ]

If yes, please complete a Supplemental Claim Form, giving details for each circumstances.

d. Please list prior professional liability insurance for each of the past five years. IF NONE, STATE NONE.

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

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