SHAND MORAHAN & COMPANY, INC.
MARKEL®
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(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

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 business premise address:

(Street) (County)

_____

(City) (State) (Zip)

(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).

[ ] $100,000 per claim; $300,000 annual aggregate
[ ] $200,000 per claim; $600,000 annual aggregate
[ ] $250,000 per claim; $750,000 annual aggregate
[ ] $500,000 per claim; $500,000 annual aggregate
[ ] $500,000 per claim; $1,000,000 annual aggregate
[ ] $1,000,000 per claim; $1,000,000 annual aggregate
[ ] $1,000,000 per claim; $3,000,000 annual aggregate

h. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... [ ] Yes [ ] No

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

2. APPLICANT PRACTICE

a. Where have you practiced your profession since graduation?

(i) In _____ (ii) In _____
State State

(iii) In _____ (iv) In _____
State State

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:

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

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

(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? .....[ ] Yes [ ] No

If No, please describe how you assess vascular flow.

If an unusual finding results, do you refer the patient to the appropriate medical practitioner? ....[ ] Yes [ ] No

(ii) Make a differential diagnosis? .....[ ] Yes [ ] No

(iii) Always record the patient's account of his/her progress? .....[ ] Yes [ ] No

(iv) Always record objective findings? .....[ ] Yes [ ] No

(v) Always record details of treatment procedures? .....[ ] Yes [ ] No

c. If the answer to any of the questions below is YES, please attach details. Do you:

(i) Use acupuncture? .....[ ] Yes [ ] No

If Yes, do you use the National Council on Certification of Acupuncturists (NCCA) clean needle technique?.....[ ] Yes [ ] No

Date last NCCA exam taken and passed._____

If No, do you use disposal needle? .....[ ] Yes [ ] No
If No, please attach details.

(ii) Dispense or prescribe: Drugs?.....[ ] Yes [ ] No
Vitamins?.....[ ] 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

4. APPLICANT OPERATIONS

a. (i) Do you use a collection agency? [ ] Yes [ ] No
If Yes, please give name of agency _____

(ii) Has the agency authority to file a collection suit at its discretion? [ ] Yes [ ] No

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.

5. STAFF

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

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

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: (Attach detailed explanation for any Yes answers)

(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.) ..... [ ] Yes [ ] No

(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... [ ] Yes [ ] No

(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? [ ] Yes [ ] No

(iv) Ever had any state professional license refused, suspended, revoked, renewal refusal or accepted only on special terms or ever voluntarily surrendered same? ..... [ ] Yes [ ] No

(v) Ever had any professional liability insurance canceled, declined, renewal refused or accepted only on special terms? ..... [ ] Yes [ ] No

(vi) Ever failed any professional licensing examination? ..... [ ] Yes [ ] No

(vii) Any chronic physical illness or defect? ..... [ ] Yes [ ] No

b. Has any claim or suit been brought against you and/or any of your employees? ..... [ ] Yes [ ] No

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? ..... [ ] Yes [ ] No

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.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception 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 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. **I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company/Underwriters**.

I AUTHORIZE any professional society, prior or present insurer, business or professional associate, licensing board, governmental entity, corporation, partnership, organization, institution or person that may have any record or knowledge concerning any claim or any of the statements and answers made herein to release such information to the Company or to Shand Morahan & Company, Inc., Underwriting Manager for the Company. I authorize the use of a copy of this authorization in place of the original.

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.

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(847) 572-6000

BROKER RISK SUMMARY

(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: