NatPro
MALPRACTICE INSURANCE

APPLICATION FOR NATUROPATHIC DOCTOR COVERAGE

INSTRUCTIONS

1. Read and answer ALL questions completely and accurately, leaving no blanks (use "N/A" if Not Applicable), as incomplete or inaccurate responses can affect coverage eligibility.
2. If you need more space for a response, continue on a separate sheet of paper and indicate the question #.
3. The application MUST be signed and dated by the applicant.
4. If your most recent policy is "claims-made" and you desire to continue coverage back to your "retroactive date," proof of continuous claims-made coverage must be submitted with this application (Current Declarations Page or Certificate of Insurance).

NOTICE: If CLAIMS-MADE COVERAGE IS CHOSEN, coverage applies only to those claims arising from naturopathic incidents which occur on or after the retroactive date stated in the policy Declarations. In addition, the claim must be first made against you and reported in writing to the company during the policy period or any applicable extended reporting period. **Please review the policy carefully and discuss the policy with your insurance representative.**

I. PRACTICE INFORMATION

1. Applicant Full Legal Name (first, middle initial, last): Dr. _____
2. Referred by: _____
3. Primary Practice Address: _____

   County: _____ City: _____ State: _____ Zip: _____

   Office Phone: _____ Mobile Phone: _____ Fax: _____

   Email Address: _____

   ❑ Secondary Practice ❑ Mailing Address: _____

   County: _____ City: _____ State: _____ Zip: _____

   Office Phone: _____ Fax: _____
4. Legal Business name of Primary Practice location: _____
5. Do you own the Practice in which you work? ❑ Yes ❑ No

   If you own your practice, what is the corporate structure of your clinic?

   ❑ Sole Proprietor ❑ Professional Corp/Partnership ❑ N/A

   Complete the following to extend coverage to an Entity/Corporation **you own,** or indicate N/A:

   ❑ N/A ❑ Shared Limits (**no additional charge**) ❑ Separate Limits (**additional charge**)

   Name of Entity **you own:** _____
6. If you are an Employee or Independent Contractor, list clinic owner's name: _____

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II. ADDITIONAL PROVIDERS

1. List any additional healthcare providers (i.e. MD, DO, PA, NP, DC, LAc, LMT, etc.) working in your practice:

   Name: _____ Check here ❑ if currently insured

   Name: _____ Check here ❑ if currently insured

   (List any others on a separate sheet)

IIi. REQUESTED COVERAGE

1. Do you currently have active Malpractice Insurance coverage? ❑ Yes ❑ No
2. *If no*, please provide an explanation:
3. **List all Professional Liability Policies** for each of the past 5 years:

Policy Period	Insurer	Limits	Annual Premium	Claims-Made / Occurrence

4. If your current policy is Claims-Made, please list your "Retroactive Date": _____
5. Requested Policy Activation Date (On or after application date): _____
6. Requested Coverage Type: ❑ Claims-Made ❑ Occurrence
7. Requested Limits of Liability (Check one):

   ❑ $1,000,000 / $3,000,000 ❑ $500,000 / $1,000,000 ❑ $250,000 / $750,000

   ❑ $200,000 / $600,000 ❑ $100,000 / $300,000 ❑ Other: _____

8. Are you requesting an additional insured be added to your policy at an additional charge? ❑ Yes ❑ No

   List the Legal business entity name: _____ Affiliation: _____

9. Requested Supplemental Defense Limits (Check one):

   ❑ $10,000 (Included) ❑ $50,000 (Additional Fee) ❑ $100,000 (Additional Fee)

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IV. APPLICANT PRACTICE PROFILE

1. Current or projected number of patients you treat, on average, per week. _____

2. Number of hours you spend in patient care, on average, per week. _____
   (Patient care includes consultation with patient, examination, treatment, documentation of care, lab time, etc.)

3. Please select the modalities below that ***you (or someone under your direct supervision)*** perform in your practice. Do not include modalities used by others when you refer to third parties)

CLASS 1

- ❑ Acupuncture/Oriental Medicine
- ❑ Western Herbal Medicine
- ❑ Physiotherapy
- ❑ Homeopathy
- ❑ Naturopathic Physical Medicine
- ❑ Nutritional Medicine
- ❑ In-Home Healthcare
- ❑ Diet and Lifestyle Counseling
- ❑ Shockwave Therapy
- ❑ Telemedicine

CLASS 2

- ❑ Injection Therapy (Subcutaneous, Intramuscular)
- ❑ Laser/Light Therapy
- ❑ Hormone Replacement Therapy
- ❑ Weight Loss Care (Medications)
- ❑ Post-Natal Care
- ❑ Medical Cannabis
- ❑ Fertility Care

CLASS 3

- ❑ Regenerative Injection Therapy (Prolo, PRP, MSCs)
- ❑ Ozone Therapy
- ❑ Prescriptions (Controlled Substances or Stimulants)
- ❑ In-Office Compounding (Non-Prescription Medications)
- ❑ Minor Surgery
- ❑ Gynecology
- ❑ Aesthetic Medicine (Botox, Fillers)
- ❑ Cryotherapy
- ❑ Weight Loss Care (Stimulants)
- ❑ IV Therapy

OTHER / SPECIFY

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V. LICENSURE / EDUCATION

1. Naturopathic College Attended: _____ Graduation Date: _____
2. License Information: First date you were licensed to practice: _____
3. List all states in which you have carried a license. Use additional sheets if needed:

Naturopathic License Number	State	Date First Licensed

4. Do you carry any other Professional Licenses? (i.e. Acupuncture, Chiropractic, Massage, etc.) ❑ Yes ❑ No

   If Yes, please specify licenses: _____

   _____

VI. RISK MANAGEMENT

1. Have you taken a continuing education course that included patient safety or risk management topics in the last two years? ❑ Yes ❑ No
2. Is patient progress documented each visit? ❑ Yes ❑ No
3. How are patient records kept?: ❑ handwritten ❑ travel card ❑ dictated ❑ software: _____
4. If necessary, would you refer to other healthcare practitioners, those patients who require additional clinical assessment, diagnosis, and/or treatment outside your scope of practice? ❑ Yes ❑ No
5. Do you utilize an informed consent form? ❑ Yes ❑ No
6. Do you require signed release forms for the release of medical records? ❑ Yes ❑ No
7. Do you utilize patient educational materials in the office? ❑ Yes ❑ No
8. Are you an active (dues paying) member of any naturopathic associations? ❑ Yes ❑ No

   If Yes, please specify: _____
9. Are you a member of any Practice Management, Coaching, or Franchise Company? ❑ Yes ❑ No

   If Yes, please specify: _____

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VII. CLAIMS HISTORY

1. Have you (or the corporation you own) ever been the subject of an investigation, complaint, reprimand, or disciplinary action, by your State Board, Governmental Agency, or an Insurance Company? ❑ Yes ❑ No
2. Have you ever had your naturopathic license suspended, revoked, voluntarily surrendered, or been placed on probation in any state? ❑ Yes ❑ No
3. Have you ever been denied, cancelled (other than for non-payment), refused renewal, or accepted only on special terms for professional liability insurance coverage? ❑ Yes ❑ No
4. Have you ever been accused or convicted of any crime, other than a minor traffic violation, in any State or Country? ❑ Yes ❑ No
5. Have you ever been treated, or sought treatment, for alcoholism, drug abuse, or mental illness? ❑ Yes ❑ No
6. Do you (or the corporation you own) have any current or prior claims? ❑ Yes ❑ No
   If Yes, you must submit a Loss Runs Report from the carrier that covered you for the claim.
7. Are you aware of any circumstance, accident or loss, including those arising from your billing practices, **that has not been reported to your insurance carrier**, but which may result in a claim or lawsuit being made against you, your predecessors in business, or against any past or present partner(s)? ❑ Yes ❑ No

   * *If you answered YES to any of the above, you will need to provide a full written explanation and complete additional forms.*

VIII. APPLICANT DECLARATIONS AND SIGNATURES

I, THE APPLICANT, DECLARE THAT I HAVE SIGNED OR TYPED MY NAME WHERE INDICTED BELOW, AND THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. I AGREE THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

I UNDERSTAND THAT BY SIGNING THIS APPLICATION, NEITHER I NOR THE COMPANY ARE REQUIRED TO COMPLETE AND BIND THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED. ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THE EARLIEST EFFECTIVE DATE FOR WHICH A POLICY MAY BE ISSUED IS THE DATE THIS APPLICATION IS RECEIVED IN OUR OFFICE.

Applicant Signature: _____ Date: _____

Applicant's Name: _____ Title: _____