Malpractice Policy

To be considered for coverage, please complete the attached application and forward it to:

Brian M Gallagher, Licensed Ins. Broker

Scott Danahy Naylon, LLC

300 Spindrift Drive

Amherst, New York 14221

1-800-728-6362 Ext: 5131

Fax (716) 633-4306

Email: bmgallagher@sdnins.com

AMERICAN ACUPUNCTURE COUNCIL

Application *for* Membership

Contact Information

Full Name (First, Middle, Last) ____________ Practice / Clinic Name ____________

Office Address (include Suite #) ____________ City ____________ State ____________ Zip ____________

Mailing Address – If Different from Office Address ____________ City ____________ State ____________ Zip ____________

Email ____________ Office Phone ____________ Cell Phone ____________ Fax ____________

Practice Background and Declaration

1. Acu License Current? ☐Yes ☐No ☐New Lic. # Pending Lic. #:____________ State:______ Issued (Mo/Yr): ____/____
2. Acupuncture School:____________ Graduated (Mo/Yr): ____/____
3. Do you hold other healthcare licenses (RN, LMT, DC, etc.)? ☐Yes ☐No If *Yes*, please list:____________
4. Referrals: When a patient needs care or diagnosis outside your scope, do you refer them to other health providers? ☐Yes ☐No
5. Record Keeping: Do you always carefully document: a) Your patient's comments to you about their condition; b) your observations and conclusions regarding their condition; and c) any treatments you provided or recommended? ☐Yes ☐No
6. Informed Consent: Do you <u>always</u> require your patients to sign an informed consent prior to treatment? ☐Yes ☐No
7. Clean Needle: Do you <u>always</u> follow clean needle technique protocols in your practice? (If ***No***, attach explanation) ☐Yes ☐No
8. Check any of the following techniques you use in your practice:

   ☐ Acupuncture During Labor ☐ Acupuncture to Turn a Breech Baby or Induce Labor ☐ Injection Therapy

   ☐ Techniques Not Taught in Acupuncture Schools (List):____________
9. Do you treat cancer, epilepsy, or acquired immune deficiency syndrome? ☐Yes ☐No If ***Yes***, do you limit your care to complementary care only, provided in coordination with the patient's medical doctor? ☐Yes ☐No (If ***No***, attach explanation)

*(If you answer **Yes** to any of the following, attach a detailed explanation including status, dates, and outcomes.)*

10. Claim History: Has any malpractice claim or allegation ever been asserted against you or your associates? ☐Yes ☐No
11. Potential Claims: Are you aware of any event or indication suggesting a claim may be made against you or that your care might have been deficient or caused harm? ☐Yes ☐No
12. License Issues: Has any agency or association ever investigated or taken any action against you or your license? ☐Yes ☐No
13. Insurance: Have you ever had malpractice insurance denied, canceled, or accepted on special terms? ☐Yes ☐No
14. Criminal History: Have you been charged with or convicted of violating any law other than a minor traffic offense? ☐Yes ☐No
15. Compromised Care: Have you ever provided care to patients when your ability to perform your professional duties was compromised because of a condition, or your use of an intoxicant, medication, or other drug? ☐Yes ☐No

Declaration: I, the applicant, hereby apply for membership/coverage and declare that I signed/typed my name below, that the above statements are true, and that I have not misstated or suppressed any facts. I understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of, my policy. I understand that if coverage is granted, I shall have the duty to report in writing, as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits. I hereby authorize release of information to the American Acupuncture Council for any underwriting or claim-related inquiry, from any acupuncture professional association, licensing board or health care organization. I understand that there is no guarantee that coverage will be renewed.

Sign here: ____________ **Date:** ____________

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AMERICAN ACUPUNCTURE COUNCIL

Application *for* Membership (A3001.SDN, Page 2 of 2)

Select Coverage and Payment Options:

1. Indicate desired Limit: ☐$2,000,000/$4,000,000 ☐$1,000,000/$3,000,000 ☐ Other (specify) ____________
2. Select ***BOTH***: a. Coverage Type: ☐ Claims Made ☐ Occurrence ***- AND -*** b. Coverage Option: ☐ Elite ☐ Preferred
3. Effective Date: Coverage, if approved, is effective the date the app is received. For a later date, specify date: ____________
4. Retroactive Coverage: Retroactive Coverage is not automatic, and there may be an additional charge. To apply for Retroactive Coverage, provide your current Declarations Page and specify a desired Retroactive Date: ____________
5. If you practice using a Professional Corp or Partnership, ***which you own***, list below to add it, free of charge, as an Additional Insured:
   ____
6. List below to add any other entity added as an Additional Insured (e.g. your Employer, Landlord, etc.). Cost is 5% per entity:
   ____
   ____
7. Who provides your current malpractice policy? ____________ Expires: ____________

Payment Detail (Refer to Quote/Rate Sheet for details)

1. **Installments:** ☐ Annual ☐ Quarterly * ☐ 10-Pay *
   * Quarterly or 10-Pay requires Auto Pay via Credit Card or ACH.
2. **Amount Due**
   - Base Coverage Amount Due ____________
   - Option: AcuProperty @ $103.20 (1) ____________
   - Option: AcuPremier @ $125 ____________
   - Option: Arb Packets @ $25/packet ____________
   - Other: ____________
   - Total Amount Due: ____________

(1) 10,000 Limit thru Lloyd's of London

Credit Card or ACH (Complete applicable section.)

Credit Card Type: ☐Visa ☐MasterCard ☐American Express

Name on Card: ____________

Card #: ____________

Expires: ____________

ACH Payments from: ☐ Personal Account ☐ Business Account

Account #: ____________

Bank Name: ____________

Bank Routing #: ____________

Bank City: ____________

Acknowledgement and Authorization

Claims Made Option: I, the applicant, declare that I have signed/typed my name below. I understand that if I have selected the Claims Made option, my policy will be limited to claims made against the insured during the policy period arising out of the rendering of, or failure to render, professional services subsequent to the retroactive date. I understand that the Claims Made option provides that if the policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless the insured purchased an Extended Coverage Policy within 30 days after termination.

Authorization: If my membership is approved, you are hereby authorized to process payment as indicated above in accordance with applicable issuer agreements. If paying by installments, I authorize that on each due date, the amount due be automatically charged to my Credit Card or debited to my Bank Account, as applicable. I understand that ACH transfers to my account must comply with the provisions of U.S. law, and that the authority to initiate debit entries as indicated will remain in effect until I have cancelled it in writing. I agree to receive communications related to my membership and coverage through Email, Fax, Phone, and/or Text.

Sign here: ____________ **Date:** ____________

Submit Application: **By Email:** acupl@sdnins.com **By Fax:** 716-633-4306

COVERAGE APPLICATION ADDENDUM

REQUESTING ADJUSTED RATE FOR PART-TIME PRACTICE

NAME OF INSURED: ______________________________

OFFICE HOURS: Indicate your normal weekly office hours by day of the week:

DAY:	SUN	MON	TUE	WED	THU	FRI	SAT
HOURS:							

HOURS WORKING EACH WEEK:

How many hours per week do you spend interacting with patients, reviewing / documenting patient files, or supervising others who are working with patients or on patient files? [ ]

How many patient appointments do you typically have each week? [ ]

How much time do you typically spend for each patient visit? This includes time spent preparing for the patient visit, meeting with and treating the patient, and completing documentation regarding the patient visit? [ ]

ANNUAL VOLUME: About how many patient visits did you have last year? [ ]

CERTIFICATION: I hereby declare the above statements are true, and I have not misstated or suppressed any facts. I understand the insurance company has the right, but not the duty, to audit my books to confirm the above is true and correct. I further understand that any fraudulent or intentional misrepresentation could result in my rate being increased, coverage being canceled, and/or a claim being denied.

Signature: ______________________________ Date: ______________________________

Name: ______________________________

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GREAT NEWS FOR YOU!

AAC is dedicated to leading the way! As a result of our striving to do better, *with our emphasis on YOU*, you will receive the **Best Customer Service** available as we provide you with a **Newly Upgraded Policy** when you renew, at **NO ADDITIONAL COST!** - More Comprehensive Coverage designed to protect you and your practice!

The **NEW COVERAGE** you will receive is due to AAC's ongoing commitment to meeting your needs and the changing needs of the profession. You can now enjoy peace of mind with the addition of **New and Upgraded coverage in your policy – See below:**

No Additional Cost Coverage Includes:

- ***$2M/4M limits*** *(your current $1M/3M limits policy will automatically double to $2M/4M limits – at NO additional COST)*
- *Premises Liability (multiple locations available)*
- *True Consent to Settle*
- *Defense Costs Outside the Limits of Liability*
- *Injection Therapy for Approved Substances (in approved States)*
- *Good Samaritan*
- *Products Liability*
- *Cyber Liability*

There is more good news regarding your policy! AAC now offers the option to increase your legal defense for supplemental coverage. (See below table) Note: If you opt for the Premier Policy option, the additional premium is only $125. If you are interested, please contact an AAC representative directly.

Acupuncture Plus (Current Policy)	Optional Acupuncture Premiere (Additional $125)
Professional Liability	Professional Liability
Premises Liability, all practice locations – Bodily Injury / Slip and Fall	Premises and General liability, all practice locations – Bodily Injury / Slip and Fall, plus Property Liability to third parties (subject to $50K Fire Liability sublimit when applicable) and Personal Injury Liability (no sublimit)
Products Liability $10,000 Sub Limit	Products Liability - $20,000 Sub Limit
Covered Proceedings - $30,000 Sub Limit	Covered Proceedings - $50,000 Sub Limit
• Board Defense	• Board Defense
• Audit Defense	• Audit Defense
• HIPAA Defense	• HIPAA Defense
• Sexual Misconduct Defense	• Sexual Misconduct Defense
Cyber Liability - $10,000 Sub Limit	Cyber Liability - $20,000 Sub Limit

Optional AcuProperty (Business Personal Property Insurance):

Business Personal Property Damage. The rate for coverage is $103.20 for $10,000 of coverage. $500 deductible. Higher limits of liability available upon request. Draft policy wording available upon request. If you are interested, please contact an AAC representative directly.

Thank you for your continued business!

1100 W. Town & Country Rd. Suite #1400 Orange, CA 92868
Phone: (800) 838-0383 Fax: (714) 571-1863 Email: info@acupuncturecouncil.com