Homeopathic Application *for* Membership

Professional Liability Coverage Application

$1,000,000/$3,000,000 Coverage: $480 Annually

Contact Data

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

Office or Mailing Address (include Suite #) ______ City ______ State ______ Zip ______

Office Phone ______ Alternate Phone (Home, Cell, etc.) ______ Fax ______ Email ______

Homeopath License # or Certificate # ______ State Issued ______ Date Issued ______ Homeopathic School Attended ______ Graduated On ______ Hours Training ______

Professional Information

1. Is your Homeopath license issued by: ☐ State ☐ City ☐ N/A Is your Homeopath certification current? (Attach Copy) ☐ Yes ☐ No
2. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If *YES*, explain) ☐ Yes ☐ No
3. Has any agency or association investigated or taken any other action against you or your license / certification? (If *YES*, explain) ☐ Yes ☐ No
4. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If *YES*, explain) ☐ Yes ☐ No
5. Have you ever used any drug or substance that interfered with your ability to perform Homeopathic duties? (If *YES*, explain) ☐ Yes ☐ No
6. Have you ever been charged with or convicted of any violation of the law other than a minor traffic offense? (If *YES*, explain) ☐ Yes ☐ No
7. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics, or make a differential diagnosis? (If *YES*, explain) ☐ Yes ☐ No
8. Do you ever prescribe or dispense any prescription drugs? (If *YES*, explain) ☐ Yes ☐ No
9. Have you ever provided Homeopathic services to a professional athlete? (If *YES*, explain) ☐ Yes ☐ No
10. Do you provide any services other than providing homeopathic remedies to promote general health? (If *YES*, attach explanation) ☐ Yes ☐ No
11. Do you provide any service other than as taught in the Homeopathic schools and colleges? (If *YES*, explain) ☐ Yes ☐ No
12. List any other health designation you hold (RN, LMT, etc.) ______ Do you separately cover these for malpractice? ☐ Yes ☐ No
13. Who provides your current Homeopathic malpractice coverage? ______ Policy Expires ______
14. To add Premises Liability ($75 / location), list address here: ______
15. List any entity you want as an additional insured *(cost is $10 / entity)*: ______
16. Your Homeopathic liability insurance, if approved, will be effective the date your app is received. For a later date, specify here: ______

Payment

Membership and Coverage (**$480** Annual/**$132** Quarterly)	
Additional Insured @ $10 / Entity	
Premises Liability @ $75 / Location	
Total Payment Remitted	

Pmt Type: ☐ Check ☐ MasterCard ☐ Visa ☐ AMEX

Card #: ______ Exp: ______

Fax or Mail Completed Application To:

SDN

SDN INSURANCE AGENCY, LLC
300 Spindrift Drive, Amherst, NY 14221
PH: 800-728-6362 FAX: 716-633-4306

Agreement & Signature

$1,000,000 / $3,000,000 Professional Liability Coverage

NO FALSE STATEMENTS: I hereby apply for coverage. If provided, charge my credit card for the amount indicated. I hereby declare that the above statements are true, and I have not misstated or suppressed any facts. I agree and 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.

CLAIMS-MADE ONLY: I understand that if coverage is granted, the policy will only cover claims made during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand 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 Extended Coverage is purchased within 30 days after termination.

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written client complaints, or threats or filings of lawsuits.

SIGN: ______ **DATE:** ______

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