“Naturopathic Plus”

Malpractice Policy

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

Eric J. Zillioux

Scott Danahy Naylon Co., Inc
300 Spindrift Drive
Amherst, New York 14221

1-800-728-6362

Fax (716) 633-4306

E-Mail: ezillioux@sdnins.com

american naturopathic council member application

Contact and Practice 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 _____

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

Naturopath License Number(s) _____ State Issued _____ Date Issued _____ Naturopath College and Location _____ Year Graduated _____

Birth Date _____ Gender: ❒Male ❒Female

Fax or Mail Completed App & Payment to:

SCOTT DANAHY NAYLON LLC

300 Spindrift Drive
Amherst, NY 14221

www.sdnins.com

Phone: 800-728-6362 / 716-633-3400
Fax: 716-633-4306
Email: naturo@sdnins.com

Payment Detail (See "Rate Sheet" for coverage choices)**:**

Installment Due: ----------

Optional Additional Insured (5% per Add Ins.) ----------

Total Payment Remitted _____

Credit Card Payments, Complete Following:

Card Type: ❒ Visa ❒ MasterCard ❒ American Express

Card #: _____

Expires: _____

You are hereby authorized to charge my credit card for the amount indicated for liability coverage through the American Naturopathic Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: _____

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Membership Application

Professional Information

1. Is your naturopathic license current? ❒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 ever investigated or taken any action against you or your license? (If *Yes*, explain) ❒Yes ❒No
4. Have you ever had malpractice insurance denied, canceled, or accepted on special terms? (If *Yes*, explain) ❒Yes ❒No
5. Have you ever used any intoxicant, narcotic, or other psychoactive drugs which interfered with your ability to perform professional duties; or have you used any illegal drug in the past year? (If *Yes*, explain) ❒Yes ❒No
6. Have you been convicted of violating any law other than a minor traffic offense? (If *Yes*, explain) ❒Yes ❒No
7. Do you treat cancer or epilepsy? (If *Yes*, explain) ❒Yes ❒No
8. Do you use stressology, internal coccyx adjustment, magnetic or gemstone therapy, or the Toftness device? (If *Yes*, explain) ❒Yes ❒No
9. Do you use any technique or therapy not taught in the naturopathic schools and colleges? (If *Yes*, explain) ❒Yes ❒No
10. Do you ever collect fees for services before the day on which you provide those services? (If *Yes*, explain) ❒Yes ❒No
11. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If *Yes*, explain) ❒Yes ❒No
12. Have you ever treated a person that was previously in a research program you sponsored? (If *Yes*, explain) ❒Yes ❒No
13. Have you used a practice management company? ❒Yes ❒No IF *Yes*, provide name: _____

14. Standard Modalities - Check each of the following treatment modalities you have used, or intend to use in your practice:

❒ Acupuncture [a]	❒ Diathermy	❒ Nutritional Therapy	❒ Ultrasound
❒ Behavioral [b]	❒ Electrical Stimulation	❒ Paracentesis	❒ Weight Control [c]
❒ Bio Feedback	❒ Homeopathy	❒ Physical Therapy	
❒ Botanical / Herbal Medicine	❒ Manipulation Therapy [a]	❒ Thoracentesis	

a *– A separate application addendum is required if you desire coverage to extend to either acupuncture or manipulation under anesthesia. Please request.*

15. Class II or Class III Modalities: Check any or all treatment modalities you have used, or intend to use in your practice:

❒ Cheletion Therapy (II or III)	❒ Hypnosis (III)	❒ Obstetrics / Deliveries (III)	❒ Prolo / Sclero Therapy (III)
❒ Colonoscopy (II)	❒ Needle Biopsies (II)	❒ Office surgery (II or III)	❒ Experimental/Other Therapy (II or III)
❒ Gynecology (II or III)	❒ Neonatal/Prenatal Care (II or III)	❒ Prescription Drugs (II or III)	

A separate application addendum must be completed and approved in order for coverage to extend to any Class II or Class III modalities. If applicable, please request an addendum promptly.

16. Do you use any technique or therapy not taught in the naturopathic schools and colleges? (If *YES*, attach explanation) ❒Yes ❒No
17. Do you treat Medicaid/Medi-Cal patients? ❒Yes ❒No *If Yes*, what % of your practice is Medicaid/Medi-Cal? _____
18. Do you make a differential diagnosis? ❒Yes ❒No *If No*, do you limit your responsibility to treating symptoms? ❒Yes ❒No
19. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (*If Yes*, explain) ❒Yes ❒No
20. If the quality of an x-ray film is marginal, do you always do, or order, a retake? ❒Yes ❒No
21. Do you <u>always</u> require your patients to sign an informed consent prior to treatment? (If *Yes*, attach copy of form you use) ❒Yes ❒No
22. Do you <u>always</u> record the patient's account of his or her progress? ❒Yes ❒No ❒No, but I will do so now.
23. Do you <u>always</u> record objective findings? ❒Yes ❒No ❒No, but I will do so now.
24. Do you <u>always</u> record details of treatment procedures? ❒Yes ❒No ❒No, but I will do so now.

american naturopathic council

Membership Application

25. When a patient needs treatment or diagnosis outside your scope of practice, do you refer them to other health providers? ❒Yes ❒No

26. List any other professional healthcare license you hold (L.Ac., N.D., RN, RPT, etc.): _____

Indicate your malpractice carrier for that other profession: _____ Expires: _____

27. Which best describes how you practice: ❒Sole Proprietor ❒Professional Corp. ❒Partnership ❒Employee ❒Contractor

28. Provide the names and practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT, etc.) of any healthcare practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (Attach additional sheets if needed):

_____ _____ _____ _____

29. To add your corporation, partnership, landlord, or other entity as an Additional Insured, list below, then check whether you require the Additional Insured to have a shared limit (5% cost), or separate limit (20% cost). Add sheets as needed:

_____ Limits: ❒ Shared ❒ Separate
Name of Additional Insured

_____ Limits: ❒ Shared ❒ Separate
Name of Additional Insured

30. Who provides your current naturopath malpractice policy? _____ Expires: _____

31. Your Naturopath insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____

32. How many patients do you see weekly? _____ How many hours / week do you spend professionally with patients? _____

33. What is the average time you spend professionally with a patient on their first office visit? _____ Follow up visit? _____

Signatures - Member Application for Coverage *(Signatures are required in all **FOUR** places below)*

NO FALSE STATEMENTS: 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.

1. Sign here: _____ **Date:** _____

CLAIMS-MADE ONLY *(Applies only if you selected a "Claims Made" Claims Reporting Basis):* I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured 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 due to nonpayment of premium or cancellation by the insured or insurer, 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.

2. Sign here: _____ **Date:** _____

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I also understand that price distinctions based on safe naturopath practices may be based in part on information provided by me in the future or during future pre-arranged office inspections. 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 patient complaints, or threats or filings of lawsuits.

3. Sign here: _____ **Date:** _____

RELEASE OF INFORMATION: I hereby authorize release of information from my professional naturopath associations & organizations, any hospitals or insurance carriers, my State Board of Naturopath Examiners, and any other relevant entity to: the American Naturopath Council or its agent, for any underwriting or claim-related inquiry. I agree that the organization releasing such information, shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors, omissions or mistakes contained therein. A photocopy of this Release Form will be as valid as the original.

4. Sign here: _____ **Date:** _____

American Naturopathic Council Application Addendum

Supplemental Professional Information

If you selected any of the items listed in Question 15 of your application, you should complete this addendum. Review the modalities listed below. Place a check mark ☑ next to each modality you are using or intend to use, then complete the requested information. If you have not used a modality yet, answer questions based on how you intend to integrate that modality into your practice. Prior approval is required for coverage to extend to any of these modalities. Complete and submit this Addendum to the Company for approval.

☐ ***Cheletion Therapy*** Currently Licensed / Certified?: ☐Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐Yes ☐ No # Hours:_____ Completed:_____

Other? (Specify where): _____ # Hours:_____ Completed:_____

Describe Training: _____
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use cheletion therapy: _____ Times per Month

Do you ever do I.V. Cheletion Therapy? ☐Yes ☐ No If *Yes*, how often: _____ Times per Month

Indicate the *percentage* of your patients with whom cheletion therapy is used: _____ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending cheletion therapy: _____

_____

_____

☐ ***Colonoscopy*** Currently Licensed / Certified?: ☐Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐Yes ☐ No # Hours:_____ Completed:_____

Other? (Specify where): _____ # Hours:_____ Completed:_____

Describe Training: _____
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you perform colonoscopies: _____ Times per Month

Indicate the *percentage* of your patients for whom you perform colonoscopies: % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending a colonoscopy: _____

_____

_____

_____

☐ ***Gynecology*** Currently Licensed / Certified?: ☐Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐Yes ☐ No # Hours:_____ Completed:_____

Other? (Specify where): _____ # Hours:_____ Completed:_____

Describe Training: _____
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you render gynecological services: _____ Times per Month

Indicate the *percentage* of patients for whom you perform gynecological procedures: _____ % of Patients

Describe the five most common gynecological services / procedures provided to patients at your office: _____

_____

_____

_____

☐ ***Hypnosis*** Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training: _____
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use hypnosis as a therapy: _____ Times per Month

Indicate the *percentage* of your patients with whom you use hypnosis as a therapy: _____ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending hypnosis therapy: _____

_____

_____

_____

☐ ***Needle Biopsies*** Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training: _____
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use needle biopsies in diagnosis: _____ Times per Month

Indicate the *percentage* of your patients with whom you utilize needle biopsies: _____ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to performing a needle biopsy: _____

_____

_____

_____

☐ ***Neo Natal / Pre Natal Care*** Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training: _____
(Nature of Curriculum) _____

Usage Indicate the *number* of patients at any time actively in your Neo Natal / Pre Natal care: _____ Times per Month

Indicate the *percentage* of patients for whom you provide Neo Natal / Pre Natal care: _____ % of Patients

Do you require all Neo Natal/Pre Natal patients to be under the concurrent care of a Neo Natal / Pre Natal physician? ☐ Yes ☐ No

Describe the diagnostic analysis you conduct prior to accepting a patient for Naturopath Neo Natal / Pre Natal care: _____

_____

_____

_____

☐ ***Obstetrics/ Deliveries*** Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training: _____
(Nature of Curriculum) _____

_____

Usage Indicate the *number* of times per month that you are involved with a delivery of a child: _____ Times per Month

Indicate the *percentage* of your patients who are pregnant: _____ % of Patients

Do you ever induce and / or stop labor ? ☐ Yes ☐ No If *Yes*, how often: _____ Times per Month

Do you ever render care while a woman is in labor? ☐ Yes ☐ No If *Yes*, how often: _____ Times per Month

Do you ever deliver babies? ☐ Yes ☐ No If *Yes*, how often: _____ Times per Month

Do you require all obstetrical patients to be under the concurrent care of an obstetrical medical doctor? ☐ Yes ☐ No

Describe the diagnostic analysis you conduct prior to accepting a patient as suitable for naturopath birthing services: _____

_____

_____

_____

☐ *Office Surgery*

Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training: _____
(Nature of Curriculum)

_____

Usage Indicate the *number* of times per month that you perform office surgery: _____ Times per Month

Indicate the *percentage* of your patients for whom you perform office surgery: _____ % of Patients

Describe the five most common surgical procedures conducted at your office: _____

_____

_____

_____

☐ *Prescription Drugs*

Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training: _____
(Nature of Curriculum)

_____

Usage Indicate the *number* of times per month that you use prescription drugs: _____ Times per Month

Indicate the *percentage* of your patients for whom you prescribe prescription drugs: _____ % of Patients

For each drug you prescribe, describe 1) the indications you observe / diagnostic analysis you conduct prior to prescribing that drug, and 2) the outcome you expect from prescribing that drug:

Drug	**Indications / Diagnosis**	**Expected Outcome**

☐ ***Prolo/Sclero Therapy*** Currently Licensed / Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training: _____
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use prolo / sclero therapy: _____ Times per Month

Indicate the *percentage* of your patients with whom prolo / sclero therapy is used: _____ % of Patients

Describe the indications you observe / diagnostic analysis you conduct prior to recommending prolo / sclero therapy : _____

_____

_____

_____

☐ ***Other/Experimental Therapy*** Currently Licensed/Certified?: ☐ Yes ☐ No If ***Yes,*** Designation: _____

Training Training as a part of your Naturopathic College curriculum? ☐ Yes ☐ No # Hours: _____ Completed: _____

Other? (Specify where): _____ # Hours: _____ Completed: _____

Describe Training: _____
(Nature of Curriculum) _____

Usage Indicate the *number* of times per month that you use some experimental therapy: _____ Times per Month

Indicate the *percentage* of your patients with whom you use some experimental therapy: _____ % of Patients

Describe the diagnostic analysis you conduct prior to recommending experimental therapy to a patient: _____

_____

_____

_____

Describe the three most common experimental procedures you used in your practice during the last twelve months:

_____

_____

NO FALSE STATEMENTS: I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my professional liability policy. I understand that untrue statements could void my insurance policy:

Print Name _____ Signature _____ Date _____

American Naturopathic Council

APPLICATION ADDENDUM
REQUESTING ADJUSTED RATE FOR PART-TIME PRACTICE

1. Name of Insured: _____

2. Please indicate the number of **Days / Week** worked at practice: _____

3. Please indicate the number of **Hours / Week** worked at practice: _____

4. Please provide your office hours for each day of the week:

   Monday: _____ hours

   Tuesday: _____ hours

   Wednesday: _____ hours

   Thursday: _____ hours

   Friday: _____ hours

   Saturday: _____ hours

   Sunday: _____ hours

5. Indicate the approximate number of patients you see weekly: _____

6. Please provide any additional information you feel would be useful to underwriting in validating your part time status:

_____

_____

_____

_____

Sign Here: _____ **Date:** _____

Based on the above information, Underwriting will determine your eligibility for Part-Time Status in connection with your Professional Liability Coverage.

AUTO PAY AUTHORIZATION

PROFESSIONAL LIABILITY INSTALLMENT PAYMENT

Installment Option (*Select one*)**:**

Name of Insured: _____

Installment Type: ☐ Annual ☐ Quarterly

Installment Amount: _____ (From Renewal Application)

Auto Pay Option (*Select one*)**:**

☐ **Bank Auto Pay (Attach Voided Check)**

Account Type: ☐ Checking ☐ Savings (select one)

Account #: _____

Bank Name: _____

Bank Routing #: _____

Branch City / State: _____

☐ **Credit Card Auto Pay**

Credit Card #: _____ (Visa, MasterCard, AMEX)

Expiration Date: _____

Authorization and Continuing Effect: Based on the Auto Pay Option I have selected, I hereby authorize the above account to be debited, or credit card to be charged, for the installment type selected; and I grant authority to initiate future debit entries as indicated until I have cancelled such authority in writing.

Changes in Amounts and Accounts: I understand that the above installment amount may change upon renewal of my coverage or as a result of other changes I may request be made to my coverage. This authorization is intended to extend to modified installment amounts, which may result from any future coverage renewal submitted by me, and to any other coverage change requested by me. In addition, I may, from time to time, approve updates to the accounts or credit cards to which this Auto Pay Option applies, by contacting your office via phone, email, customer service portal, or by mail. This authorization is intended to apply to any such updates.

Sign Here: _____ **Date:** _____