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

NATIONAL CHIROPRACTIC COUNCIL

Application *for* Membership

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 _____

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

Birth Date _____ Gender: ☐ Male ☐ Female

Fax or Mail Completed App & Payment to:

SDN INSURANCE AGENCY, LLC

300 Spindrift Drive
Amherst, NY 14221

www.sdnins.com

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

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

Installment Due: _____

Optional Additional Insured (5%) _____

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 National Chiropractic Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: _____

NATIONAL CHIROPRACTIC COUNCIL

Membership Application

Professional Information *(Attach Additional Sheets When Needed)*

1. Is your chiropractic 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*, attach explanation) ❒Yes ❒No
3. Has any board, agency, association, or insurer investigated or taken any action involving 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*, attach explanation) ❒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*, attach explanation) ❒Yes ❒No
6. Have you been charged with or convicted of violating any law other than a minor traffic offense? (If *Yes*, attach explanation) ❒Yes ❒No
7. Do you ever use stressology, internal coccyx adjustment, magnetic or gemstone therapy, or the Toftness device? (If *Yes*, explain) ❒Yes ❒No
8. Do you practice obstetrics or colonics? (If *Yes*, attach explanation) ❒Yes ❒No
9. Do you treat cancer or epilepsy? (If *Yes*, attach explanation) ❒Yes ❒No
10. Do you ever administer anesthesia (other than topical or by means of local infiltration)? (If *Yes*, attach explanation) ❒Yes ❒No
11. Do you ever prescribe, dispense, or administer any prescription drugs? (If *Yes*, attach explanation) ❒Yes ❒No
12. Check to indicate whether you use, or intend to use, in your practice: ❒Manipulation under anesthesia ❒ Laser treatment ❒ Breast Thermography (A separate addendum must be completed and approved to activate coverage for these treatment modalities.)
13. Do you use any technique not taught in the chiropractic schools and colleges? (If *Yes*, attach explanation) ❒Yes ❒No
14. Do you make a differential diagnosis? ❒Yes ❒No *If No*, do you limit your responsibility to treating symptoms? ❒Yes ❒No
15. If the quality of an x-ray film inhibits your ability to properly diagnose a patient's condition, will you always require a retake? ❒Yes ❒No
16. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (*If Yes*, explain) ❒Yes ❒No
17. 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
18. Do you <u>always</u> record the patient's account of his or her progress? ❒Yes ❒No ❒No, but I will do so now.
19. Do you <u>always</u> record objective findings? ❒Yes ❒No ❒No, but I will do so now.
20. Do you <u>always</u> record details of treatment procedures? ❒Yes ❒No ❒No, but I will do so now.
21. When a patient needs treatment or diagnosis outside your scope of practice, do you refer them to other health providers? ❒Yes ❒No
22. How many patients do you see weekly? _____ How many hours / week do you spend professionally with patients? _____
23. What is the average time you spend professionally with a patient on their first office visit? _____ Follow up visit? _____
24. Do you treat Medicaid/Medi-Cal patients? ❒Yes ❒No *If Yes*, what % of your practice is Medicaid/Medi-Cal? _____
25. List any practice management company you have used *(If none, indicate so)*: _____
26. Do you ever collect fees for services before the day on which you provide those services? (If *Yes*, attach explanation) ❒Yes ❒No
27. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If *Yes*, attach explanation) ❒Yes ❒No
28. Have you ever treated a person that was previously in a research program you sponsored? (If *Yes*, attach explanation) ❒Yes ❒No
29. Who provides your current chiropractic malpractice policy? _____ Expires: _____
30. Your Chiropractic insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____
31. List any other professional healthcare license you hold (L.Ac., N.D., RN, RPT, etc.): _____
    Indicate your malpractice carrier for that other profession: _____ Expires: _____
32. 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):

_____ _____ _____ _____

NATIONAL CHIROPRACTIC COUNCIL

Membership Application

33. Which best describes how you practice: ☐Sole Proprietor ☐Professional Corp. ☐Partnership ☐Employee ☐Contractor

34. 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

35. List any current chiropractic specialty designations / certifications held: _____

36. List any chiropractic awards, teaching appointments, or published works: _____

_____

37. If you have held hospital privileges or completed a residency, provide the following (Attach additional sheets if needed):

_____ _____ _____
Hospital Name and Location | Dates Affiliated | Nature of Privileges / Reason for Termination

38. List pre-chiropractic college education: _____ _____ _____
College | Yr Graduated | Degree

➢ 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 any price distinctions based on safe chiropractic 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 chiropractic associations & organizations, any hospitals or insurance carriers, my State Board of Chiropractic Examiners, and any other relevant entity to: the National Chiropractic 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:** _____

Coverage Comparison

An ***occurrence policy*** provides coverage for any incident that occurs during the policy period regardless of whether or not the policy is still in effect at the time the claim is made. An advantage of the occurrence coverage form is the certainty that a claim will be covered if the incident from which the claim arose occurred during a time when insurance was in place. Also, there is no need to obtain additional coverage upon termination of coverage as would be necessary with a claims-made policy.

A ***claims-made policy*** provides coverage for claims that occur subsequent to the retroactive date and reported to the insurer while the policy is still in force. The retroactive date is the first date on which an incident may occur and be covered by the policy; usually the date the policy was initially purchased (1st policy effective date). It is important to understand the concept of claims-made insurance coverage, in order to prevent potential gaps in coverage.

The major difference between occurrence and claims-made coverage forms is that with the occurrence form, claims do not have to be reported before the termination of the insurer-insured relationship, under the claims-made form, they do; unfortunately, it may not be possible to do so. Therefore, to ensure coverage of incidents that occurred prior to termination but were reported after expiration of the last policy period, the insured must purchase either an extending reporting endorsement, commonly known as "tail" coverage, from the former insurer, or prior acts coverage with the new insurer. This endorsement in effect converts a claims-made policy to an occurrence policy by extending coverage to include those claims that occurred previously, no matter when they are reported.

Initially, occurrence coverage may appear to be more costly than claims-made. The cost of a claims-made policy changed during the first few years of coverage as the policy matures, with the cost of the first year being the lowest and increasing each year until the 5th year, when it is considered mature. The price of a claims-made policy is initially more attractive, due to the discounts in the first 4 years, but keep in mind that there is a cost involved if "tail" coverage needs to be purchased. After a number of years under either program the premium differences tend to be immaterial.

I have read the description of the two forms and elect to purchase:

_____ **An Occurrence Form Policy**

_____ **A Claims Made Form Policy**

If your current coverage is a Claims Made Form and you are now requesting an Occurrence Form policy, you need to purchase "tail" coverage from your current carrier. If "tail" coverage is not purchased and a claim is filed from the period you were covered by a Claims Made policy, the claim will not be covered by either policy.

(Signature) (Date)

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: _____

PAYMENT AUTHORIZATION

CREDIT CARD OR ACH – ONE TIME OR RECURRING PAYMENTS

When making payments with a Credit Card or ACH, use this form to set up either a one-time payment or recurring installment payments. Complete all four sections below. Sign and date where indicated to authorize payment(s).

1. **Name of Insured:** _____

2. **Payment Amount and Frequency:**
   - **Amount** to be Charged or Debited: $ _____
   - **Frequency** of Payment: ☐ Annual (One time Charge) ***or*** Installments[1] ☐ Quarterly

   1 - Quarterly requires Autopay via Credit Card or ACH.

3. **Method of Payment:** (Complete only the applicable section)
   - **Credit Card Payments:**

     Credit Card Type (select one): ☐Visa ☐MasterCard ☐American Express

     Name on Account[2]: _____

     Card #: _____

     Expiration: _____
   - **ACH Payments:**

     Account Type (select one): ☐ Personal Account ☐ Business Account

     Name on Account[2]: _____

     Account #: _____

     Bank Name _____

     Bank Routing #: _____

     Branch City/State: _____

   2 - If Name on Account is not the Name of the Insured, Complete Section 5, below.

4. **Payment Authorization:** I, the Authorized Signatory on the account indicated above, declare that I signed/typed my name below. 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 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.

   Authorized Signatory on Account Sign Here: _____ **Date:** _____

5. **Refunds *(Complete only if Name on Account is not the Named Insured)*:** I, the Named Insured, declare that I signed/typed my name below. Should a refund be made in connection with coverage paid for as a result of this Payment Authorization Form, the refund should be issued to the person listed as the Name on Account above.

   Named Insured Sign Here: _____ **Date:** _____