



Application

FOR

CHIROPRACTORS

Professional Liability Insurance



Home Office: 1 11 East Shore Road, P.O. Box 4300
Manhasset, New York, 11030-2902
Telephone: (718) 895-6033 (516) 365-6690
(212) 936-3050 (800) 632-6040
Fax: (516) 365-6343

Rochester Office: 1200C Scottsville Road, Suite 195
Rochester, New York, 14624
Telephone: (716) 328-8860 (800) 329-8860
Fax: (716) 328-8686

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any applicable endorsements, has been issued to the named insured.

Help us expedite the processing of your application:

- Please print your responses in ink or type.
- Answer every question or mark it "not applicable" (N/A).
- Use the "Remarks" section to amplify your answers, where requested (see #35)
- If you have had claims or suits filed against you, please make certain you have completed a claims information form for each claim or suit in the past ten years. (See page 15).
- Signature required on Consent Option Form and pages 13 & 14.
- Incomplete answers and/or missing attachments **will** delay our processing of the application.

FOR ASSISTANCE, CHIROPRACTORS MAY CALL EITHER OF OUR OFFICES
AT ANY ONE OF THE NUMBERS LISTED ABOVE



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CONSENT OPTION

Physicians' Reciprocal Insurers has obtained Insurance Department approval for a 5% premium reduction for policy holders who opt to forego the customary consent to settle any claim.

Please indicate by checking the appropriate box below, the option that you wish.

"NO CONSENT" OPTION

I hereby authorize PRI to act on my behalf to settle any claim reported, or to appeal any judgement against me without first obtaining my written consent.

"CONSENT" OPTION

I wish to maintain the terms of the policy which under Section I, Part 4 currently requires PRI to obtain my written consent prior to settling any claim on my behalf or appealing any judgement on my behalf.

Signed: _____ Date: _____

Print Name: _____

Policy Number (*if known*): _____

PHYSICIANS' RECIPROCAL INSURERS**APPLICATION FOR CHIROPRACTORS****A. GENERAL INFORMATION** (Please type or print clearly in ink).

If my application is approved, make coverage effective on ____/____/____ (if possible) otherwise, on any other date set by the Exchange.

1. **Name** _____ (_____), D.C.
 First Middle Last Maiden

2. **Date of Birth:** _____

3. **Male** **Female**

4. **Social Security #:** _____ **IRS Tax ID #:** _____

5. **NYS License #:** _____

List all non-NYS chiropractic licenses (if applicable):

a. _____ c. _____

b. _____ d. _____

If you have more than four non-NYS licenses, please list in # 35 and explain.

6. **Home Address:** _____ () _____
 Number Street Telephone

_____ () _____
 City County State Zip Telephone

7. **Mailing address (choose one):** Home Primary Address

Other (Specify) _____
 (Explain in Remarks, # 35)

B. PRACTICE LOCATIONS

List all locations, other than hospitals and ambulatory surgery center, at which you currently render professional services. Include all office locations, nursing homes, urgent care clinics, and other non-hospital locations.

8. Primary address for which coverage is desired:

_____ () _____
Number Street Telephone

_____ () _____
City County State Zip Fax

This address is a (check one):

Private office Clinic Other _____

Number of hours per week: _____ Number of patients per week: _____

9. Other address for this policy (if any):

_____ () _____
Number Street Telephone

_____ () _____
City County State Zip Fax

This address is a (check one):

Private office Clinic Other _____

Number of hours per week: _____ Number of patients per week: _____

If this policy is for more than two locations, list other locations in # 35.

C. TRAINING

10. a. Chiropractic Education: _____
School State

Graduation Date

b. Is your practice specialized? Yes No

If yes, please list specialty (ies). _____

c. Are you board certified in these specialties? Yes No

If yes, list designations and certifying organizations.

Designation	Organization
_____	_____
_____	_____
_____	_____

d. Do you hold any other professional licenses/certificates in New York State?

Yes No

If yes, please provide details.

D. PROFESSIONAL & INSURANCE HISTORY

11. Practice Locations

List all locations at which you have practiced in the last ten (10) years. Explain any gaps in time and attach additional pages as needed.

Name of Practice/Employer	Address	From Mo/Yr	To Mo/Yr
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Prior Insurance

Provide the name(s) of professional liability carrier(s), policy number(s) and coverage period(s) of all professional liability insurance policies under which you have been insured in the past ten (10) years. If you are applying for Prior Acts Coverage, please complete the following for the entire Prior Acts Coverage period. Attach additional pages as needed.

Coverage Period From/To	Insurance Carrier	Policy Number	Limits of Liability	Type of Policy CM/OCC.	# of Claims
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

13. Insurance History

a. Have you **ever** practiced without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage?

Yes No

If yes, explain in # 35.

b. Have you **ever** had professional liability insurance refused, declined, canceled or accepted on special terms?

Yes No

If yes, explain in # 35.

c. Have you **ever** been required to pay an additional merit-rated premium or have you ever been involved in an appeal concerning the imposition of such a surcharge?

Yes No

If yes, explain in # 35.

E. COVERAGE OPTIONS

14. Limits of Liability

Please check the desired limits of liability:

- \$100,000 per claim/ \$300,000 annual aggregate
- \$200,000 per claim/ \$600,000 annual aggregate
- \$500,000 per claim/ \$1,000,000 annual aggregate
- \$1,000,000 per claim/\$3,000,000 annual aggregate

15. Coverage Type

PRI offers both Claims - Made and Occurrence coverage.

- * A Claims – Made policy covers claims which arise and are made while the policy is in force.
- * An Occurrence policy protects the policy holders against claims arising during the policy period, regardless of when the claim is reported.

Select coverage type: Claims-Made Occurrence

16. Prior Acts Coverage

a. Is this policy to replace an existing Claims-Made Policy?

Yes No

b. Do you wish to have prior acts coverage (nose) beginning on the initial issue date of your existing Claims-Made Policy?

Yes No

c. Do you know of any incidents that may give rise to claims for chiropractic services which you provided during the period for which prior acts coverage is desired, and that you have not reported to your current carrier or carrier of record?

Yes No

If yes, please explain: _____

For prior acts coverage, a Conversion Supplemental Application (E-104A) must accompany this application, along with a copy of your most recent declarations page.

17. Scope of Coverage

- I am requesting coverage for my entire chiropractic practice as described in this application.
- I do not want PRI coverage for the part of my chiropractic practice listed below.

Complete the following section to specify the part of your practice for which you do **not** want PRI coverage. Please **include the location(s)** of the practice(s) and proof of coverage from the professional liability carrier providing coverage for that aspect of your practice.

Practice/Location	Carrier/Limits	Dates
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Practice/Location	Carrier/Limits	Dates
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F. PROFESSIONAL CONDUCT INFORMATION

18. Governmental Action

- a. Has any government agency **ever** investigated, suspended, revoked or taken any other action against your license to practice?
 Yes No

If yes, explain in # 35.

- b. Have you ever been convicted of a crime?
 Yes No

If yes, explain in #35.

19. Health

Do you have any health problem, illness or physical condition that impairs or may impair your ability to practice chiropractic?

Yes No

If yes, please submit a letter from your treating health care practitioner addressing your state of health and whether any condition exists which could adversely affect your practice.

20. Claims/Suits

Have you **ever** been named as a defendant in a malpractice claim or suit, or are you presently involved in malpractice litigation?

Yes No

If yes, submit a separate form for each case in the last 10 years. (See page 15)

G. PRACTICE ASSOCIATIONS

Reminder: Answers to the questions in this section should reflect your **intended** practice as of the date you wish this policy to become effective.

21. Practice Situation

a. Indicate all practice situations which apply to you:

- | | |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> "Solo" Chiropractor | <input type="checkbox"/> Employed by another chiropractor |
| <input type="checkbox"/> "Solo" Professional Corporation | <input type="checkbox"/> Employs another chiropractor |
| <input type="checkbox"/> Professional Corp. with more than one chiropractic shareholder | <input type="checkbox"/> Limited Liability Partnership |
| <input type="checkbox"/> Chiropractic partnership | <input type="checkbox"/> Limited Liability Company |
| <input type="checkbox"/> Independent Contractor/Contractee | <input type="checkbox"/> MSO/MDDC arrangements |
| <input type="checkbox"/> Use of assumed name (DBA) | |

If you check any boxes above **other than** "Solo" chiropractor or "Solo" Professional Corporation, list below the name(s) of the applicable entity(ies) and/or the names of any chiropractors who are part of these organizations. **Please attach copies of your letterhead(s) to this application.**

Name of Entity(ies)	Name of Chiropractor Employer/Employee	Professional Liability Insurance Carrier
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Do you desire coverage for any of the above entities: Yes No

If yes, which one(s): _____

If P.C. or partnership coverage is desired, please submit a copy of the Certificate of Incorporation or Certificate of Partnership and filing receipt.

22. Other Chiropractors

Do you practice with other chiropractors not listed above? Yes No

If yes, list the name(s) of the chiropractor(s) with whom you practice and describe the association.

Chiropractor(s)	Nature of Association
_____	_____
_____	_____
_____	_____

23. Other Professional Personnel

a. List number of professional classification of any chiropractic assistants or other ancillary staff you employ or lease:

Number	Classification
_____	_____
_____	_____
_____	_____

b. Is coverage desired for these staff? Yes No

If yes, submit proof of training and list of duties.

- c. Do your chiropractic assistants provide any patient care without a chiropractor being present in the office? Yes No

If yes, please describe.

H. ADMINISTRATIVE AND TEACHING RESPONSIBILITIES

24. Additional Responsibilities

Do you have any administrative or teaching responsibilities outside of your practice?

- Yes No

If yes, complete questions a - d. Attach additional pages if necessary.

- a. Name and address of entity:

- b. Your title: _____

- c. Describe your responsibilities:

- d. Does the entity provide you with coverage for:

- i) Your administrative responsibilities? Yes No

- ii) Your direct patient care? Yes No

NOTE: Please be advised that coverage is not provided for any liability assumed solely as a result of your role as medical director of any facility. However, coverage is provided for direct patient care.

I. PRACTICE & PROCEDURES

25. Do you desire coverage for acupuncture? Yes No

If yes, provide copy of state certificate.

26. Which of the following techniques do you use in your practice? (Check all that apply.)

- a. Upper cervical specific
- b. Instrumental adjusting
- c. Applied kinesiology
- d. Direct non-force
- e. Sacro - occipital
- f. Diversified adjusting
- g. Logan Basic Technique
- h. Flexion Distraction
- i. Stressology
- j. Reflexology
- k. Surrogate
- l. Gonstead
- m. Other (please list) _____

27. Do you provide any of the following treatments or use any of the following diagnostic methods?

- a. Use of magnets Yes No
- b. Use of crystals Yes No
- c. Treatment of animals Yes No If yes, ___% of practice.
- d. Use of iridology Yes No

28. Use of X-Rays

- a. Do you take diagnostic x-rays in your office? Yes No
- If yes, do you provide this service for outside practices? Yes No
- * Are follow-up x-rays taken? Yes No
- b. Do you refer patients for x-rays, MRIs, CT scans? Yes No

29. Do you sell vitamins, herbs, homeopathic remedies or any other products?

Yes No

If yes, please describe. _____

30. Do you make a differential diagnosis?

Yes No

31. Referrals

a. Do you refer patients to other health care providers? Yes No

b. Do you send patients for blood tests? Yes No

32. List name(s) of all chiropractic association(s) of which you are a member:

33. Does your practice advertise?

Yes No

Please provide copies of all advertisements.

34. Fees/Discounts

a. Do you charge case fees? Yes No

If yes, please describe the circumstances under which you do.

b. Do you offer cash discounts? Yes No

I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not misrepresented or withheld any information which is calculated to influence the judgment of the Exchange in considering this application for professional liability insurance.

AGREEMENT: I understand that the policy being applied for does not cover liability of others which I may have assumed under any contract or agreement, including PPO, HMO and all other managed care organizations. To assure proper protection I agree to submit a copy of such contract or agreement to the Exchange for underwriting consideration together with this application.

The application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant or the Exchange to issue coverage.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

Signature: _____ Date: _____
(Applicant's Signature)

PRINT NAME

I understand that in order to underwrite professional liability insurance, The Exchange must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, underwriter, and insurance agent to furnish any information concerning me or my medical practice which the company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Exchange pursuant to this consent and direction, together with the agents, employees, or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information may be wrong.

I understand and agree that, if I am approved as a Subscriber to the Exchange and a policy is issued to me, there is a continuing obligation on my part to update and keep current all of the information furnished by me as part of this application.

Signature: _____ Date: _____
(Applicant's Signature)

PRINT NAME

CLAIM INFORMATION

Be Sure to Answer All Questions Fully. Leave No Blanks

- A. Name of claimant or plaintiff: _____
- B. Date of alleged incident _____
- C. Name of Defense Counsel _____
- D. Name of Plaintiff's Counsel _____
- E. Location of Incident (County and State) _____
- F. Date of Incident _____
- G. Report Date _____
- H. Issue or type of injury claimed - What was the objective issue contested in this Claim?
 Injury: Emotional Only Cosmetic Temporary Disability
 Permanent Disability Death Injury with Economic Impact
 Treatment Involved: _____
 Please state allegations filed against you by patient: _____

At what point in the treatment provided could this incident have been avoided either by a different action on your part or help from another treating chiropractor? Please be candid.

- I. Were other Chiropractors involved as co-defendants? Yes No
 If yes, please list their names

the If you were one of many defendants in this legal action and your treatment was criticized by any of chiropractors involved, what were the allegations against you?

- J. Name of the insurance company defending you: _____
- K. Was claim or suit actually brought against you, merely threatened, or limited to claimant's attorney contact? _____
- L. If suit was filed, include the court docket number, if known: _____
- M. Disposition of Claim: What happened to the claim?
 * OPEN Current Status: _____
 How much has the insurance company set aside in reserve for this claim? (if known) _____
 * CLOSED Date Closed: _____
 Won by defense
 Judgment Verdict
 Won by claimant

Amount paid on your behalf? _____
Reason for payment on your behalf: _____

PHOTOCOPY THIS FORM AND SUPPLY US WITH A SEPARATE SHEET FOR EACH CLAIM, SUIT OR INCIDENT.