NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

CHIROPRACTOR SUPPLEMENTAL APPLICATION

COMPLETE IN FULL INCLUDING SIGNATURES AND DATING BY THE PROVIDER NOT EARLIER THAN 45 DAYS BEFORE THE PROPOSED EFFECTIVE DATE OF COVERAGE.

ATTACH ADDITIONAL SHEETS AS NECESSARY.

ANSWER ALL QUESTIONS. If not applicable, indicate N/A.

GENERAL INFORMATION

1)

Named Insured:			
Degree Designation:			
Chiropractic License #:		State of License:	
Health Care Licenses (if applicable):	☐ MD ☐ DO ☐ DPM ☐ ND ☐ RN ☐ RPT ☐ LAC ☐ Other: _____		
Date of Birth:			
US Citizen? Yes ☐ No ☐		Social Security Number:	
Immigration status:		Entry date:	
Brokerage/Broker:		Agency/Agent:	
Renewal? Yes ☐ No ☐		Policy Number:	
Effective Date:			
Website:			

2) Current/Most Recent Professional Liability Carrier Information:

Carrier:					
Limit of Insurance:					
Deductible:		Premium:			
Policy Term Dates:					
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐		Retroactive date:		

3) Current/Most Recent Commercial General Liability Carrier Information:

Carrier:					
Limit of Insurance:					
Deductible:		Premium:			
Policy Term Dates:					
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐		Retroactive date:		

Please attach copies of the following:

a) Currently valued five year loss runs, including claim detail for all losses

b) Copy of your current Professional Liability insurance Declarations Page and Commercial General Liability insurance Declarations Page (claims made policies must reflect the retroactive date and limits for retro continuity)

c) A copy of all marketing materials, brochures, etc. if a website is not available

d) A copy of your Curriculum Vitae

e) A copy of your business letterhead

f) A copy of all licenses and board certifications held by you

g) A copy of all reporting endorsements previously issued to you

4) Mailing Address: _____

City: _____ State: _____ Zip Code: _____

5) Practice Address: _____

City: _____ State: _____ Zip Code: _____

6) Are you a(n): ☐ Corporation ☐ Individual ☐ Partnership ☐ LLC
☐ Employed Chiropractor ☐ Contracted Chiropractor ☐ Other: _____

a. If you are employed or contracted, by whom? _____

7) Your practice is: ☐ Solo Practice ☐ Group Practice ☐ Other: _____

8) What is the entity name of your practice? _____

a. What is your ownership percentage? _____ %

b. How many other professionals practice at this entity? _____

c. Are you seeking coverage for this entity? If yes please attach articles of incorporation. Yes ☐ No ☐

PRACTICE SPECIALTY AND EDUCATION INFORMATION

9) Please complete the below table for all locations and dates of practice you have had in the last ten years:

Practice Name	City/State	Beginning Date	End Date

10) Please complete the following table for your education history:

	Institution	Location	Degree/Specialty	Completed?
Chiropractic School				Yes ☐ No ☐
Internship				Yes ☐ No ☐
Residency				Yes ☐ No ☐
Fellowship				Yes ☐ No ☐

11) What date did you begin practicing chiropractic? _____

12) Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy act? Yes ☐ No ☐

a. If yes, have you implemented procedures to comply with the HIPPA Privacy Rule? Yes ☐ No ☐

b. Who is your Privacy Officer? _____

13) Are you a member of any professional societies/organizations? Yes ☐ No ☐

a. If yes, which one(s)? _____

_____

PRACTICE AND PROCEDURE INFORMATION

14) Please complete the following table for procedures/treatments that you perform. Check and complete all that apply:

Procedure	Number Performed Last 12 Months	Estimated Number Performed Next 12 months	Procedure	Number Performed Last 12 Months	Estimated Number Performed Next 12 months
☐ General meric adjusting			☐ Acupuncture (complete question 17))		
☐ Massages			☐ Upper cervical specific		
☐ Short wave diathermy			☐ Instrumental adjusting		
☐ Kinesiology			☐ Gonstead/diversified		
☐ Mechanical Traction			☐ Direct non-force		
☐ Whirlpool			☐ Sacro-occipital		
☐ Stressology			☐ Hydroculator/heat packs		
☐ Internalcoccyx adjustment			☐ Electrical stimulation		
☐ Gemstone therapy			☐ Ice-cryotherapy		
☐ Toftness device			☐ Trigger point therapy		
☐ Colonic irrigations			☐ Cold Laser		
☐ Cancer treatment			☐ Epilepsy treatment		
☐ Autism treatment			☐ Other mental or behavioral condition treatment		
☐ Activator			☐ Galvanci		
☐ Manipulation under anesthesia			☐ Pain Management Injections		
☐ Ultraviolet			☐ Ultrasound		
☐ Aesthetic Mecidine			☐ Other: _____		
☐ Other: _____			☐ Other: _____		
☐ Other: _____			☐ NONE OF THE ABOVE	INITIAL TO CONFIRM: _____	

15) If you are performing acupuncture, please complete the following:

a. Do you use the National Council on Certification of Acupuncturists (NCAA) clean needle technique? Yes ☐ No ☐

b. Date of last NCCA exam taken and passed: _____

c. If no to a., do you use disposable needles? Yes ☐ No ☐

d. If no to a. and c., please attach details about your needle protocols.

16) What are your average weekly practice hours? _____

17) How many weekly patient encounters do you have on average? _____

18) What is the approximate gross annual income from your practice? $_____

19) Have there been any changes practice activities in the last ten years, including any planned changes in the next 12 months? Yes ☐ No ☐
   a. If yes, please attach an explanation.

20) Do you perform any procedures not routinely performed by others practicing in your specialty or subspecialty? Yes ☐ No ☐
   a. If yes, what procedures? _____

21) Do you use the Georges Test, the Vertebral Artery Ischemia Test, or the Cerebrovascular Craniocervical Function Test when initially seeing a patient or when seeing a patient you have not seen for six or more months? Yes ☐ No ☐
   a. If no, please attach an explanation clarifying how you assess vascular flow.
   b. If test results show an unusual finding, do you refer the patient to the appropriate medical practitioner? Yes ☐ No ☐

22) Please complete the following. For all "no" answers, please attach an explanation:
   a. Do you ever make a differential diagnosis? Yes ☐ No ☐
   b. Do you always record the patient's account of his/her progress? Yes ☐ No ☐
   c. Do you always record objective findings? Yes ☐ No ☐
   d. Do you always record details of treatment procedures? Yes ☐ No ☐

23) Do you or any entity named in this application own, operate, administer, maintain a relationship with, or supervise any hospital, nursing home, surgi-center, clinic or other facility where healthcare services are customarily rendered? Yes ☐ No ☐
   a. If yes, please attach details.

24) Are you affiliated with any hospitals? Yes ☐ No ☐
   a. What facility(ies) are you affiliated with? _____
   _____

25) Are you employed by the federal, state or local government (full or part time, including active duty military)? Yes ☐ No ☐
   a. If yes, please attach details.

26) Do you treat patients in a nursing home, correctional facility, or similar care facility? Yes ☐ No ☐
   a. If yes, what percentage of your practice are these operations? _____ %
   b. Please list the facilities: _____
   _____

27) Do you dispense or prescribe any drugs? Yes ☐ No ☐
   a. Do you dispense or prescribe any vitamins or supplements? Yes ☐ No ☐
   b. If yes to 29) or a., please attach a complete list of drugs, vitamins, or supplements you dispense or prescribe.

28) Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? Yes ☐ No ☐
   a. If yes, please attach a detailed list of the procedures or drugs and a description of protocols and procedures.

29) Do you utilize x-rays or other imaging in treatment determination? Yes ☐ No ☐
   a. If yes, please attach details.
   b. Are x-rays read by a radiologist? _____

30) Do you engage in any procedure that requires penetration of the skin other than acupuncture or the drawing of blood for diagnostic purposes? Yes ☐ No ☐
   a. If yes, please attach details.

31) Do you practice animal chiropractic? Yes ☐ No ☐

a. If yes, please attach details.

STAFF INFORMATION

32) Please complete the following for your staff:

	Number Employed		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full-Time	Part-Time	Full-Time	Part-Time		
Chiropractor					Yes ☐ No ☐	Yes ☐ No ☐
Chiropractor Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Nurse Practitioner					Yes ☐ No ☐	Yes ☐ No ☐
RN					Yes ☐ No ☐	Yes ☐ No ☐
LPN					Yes ☐ No ☐	Yes ☐ No ☐
Physical Therapist					Yes ☐ No ☐	Yes ☐ No ☐
Massage Therapist					Yes ☐ No ☐	Yes ☐ No ☐
X-Ray Technician					Yes ☐ No ☐	Yes ☐ No ☐
Lab Technician					Yes ☐ No ☐	Yes ☐ No ☐
Student/Preceptors					Yes ☐ No ☐	Yes ☐ No ☐
Other: _____					Yes ☐ No ☐	Yes ☐ No ☐

33) Are all of the individuals included in the table above licensed in accordance with applicable State and Federal regulations? Yes ☐ No ☐

34) Do engage in any business other than the practice of chiropractic? Yes ☐ No ☐

a. If yes, please attach details.

35) Do you share office space or have an expense sharing arrangement with any other chiropractor other than those named above? If yes, please attach an explanation. Yes ☐ No ☐

36) Which of the following procedures do you use for hiring/screening professionals and paraprofessionals who provide patient care services in your operations other than surgeons and anesthesia providers? Check all that apply:

☐ Check of educational background
☐ Check of residency program
☐ Check of previous employers – In writing
☐ Check of previous employers – By telephone
☐ Criminal background check – State
☐ Criminal background check – Federal
☐ Drug screening
☐ Alcohol screening
☐ Abuse screening
☐ Reference verification
☐ Verification of license validity, suspensions, revocations, citations, or pending disciplinary actions
☐ Verification of any pending disciplinary actions by current or previous employers
☐ Verification of Professional Liability or other workplace related claims history against the applicant
☐ Other: _____

COVERAGE AND LOSS HISTORY

37) Has any licensing authority taken any action against you or any of your employees? Yes ☐ No ☐

If yes, please attach an explanation and copies of all citations.

38) Have you or any of your employees ever had any professional license or license to prescribe and or dispense narcotic ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **If yes, please attach an explanation.** Yes ☐ No ☐

39) Have you or any of your employees ever been charged with or convicted of a crime other than minor traffic violation(s)? **If yes, please attach an explanation.** Yes ☐ No ☐

40) Have you or any of your employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? Yes ☐ No ☐

41) During the past five years, has any insurer ever canceled or non-renewed similar insurance to any applicant or has your insurance been canceled for nonpayment of premium by any insurance or finance company. **If Yes, please attach an explanation.** Yes ☐ No ☐

42) Have you ever practiced without Professional Liability insurance in place? Yes ☐ No ☐

43) Do you have Professional Liability insurance in place for work you do elsewhere? **If yes, please attach a copy of the policy Declarations page(s).** Yes ☐ No ☐

44) Has any claim or suit for medical malpractice or professional liability ever been filed, or any claim otherwise been made against you or any other person proposed for this insurance, including any partnership or joint venture of which you have been a member or your company's predecessors in business? Yes ☐ No ☐

a. **If yes, please complete the Kinsale Health Care Claim Supplemental.**
b. How many malpractice or professional liability claims have you had? _____
c. Have these claims all been reported to your current or a prior insurer? Yes ☐ No ☐

45) Are you or anyone else proposed for this insurance aware of any occurrences, facts, circumstances, incidents, situations, act, error, omission or records request from a patient or their attorney which may result in a claim or suit? **If yes, please complete the Kinsale Health Care Claim Supplemental.** Yes ☐ No ☐

46) If your Professional Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

47) If your Commercial General Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 subjects the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____