HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

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

ACUPUNCTURISTS

PROFESSIONAL AND GENERAL LIABILITY INSURANCE

(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter with whom you are working.
For contact information please visit www.usrisk.com/healthcare.html

1. APPLICANT INFORMATION:

a. Complete name of applicant (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary):** _____

Address: _____

City: _____ State: Zip _____ County: _____

Contact name: _____ Title:_____ Email address: _____

Phone: _____ Web site Address: _____ Fax: _____

List all other locations **(use an additional sheet of paper if necessary):** _____

b. Professional degree: _____

c. Place of Birth: _____

d. Applicant is (check all that apply):

❑ U.S. Citizen (If not, provide status)	❑ Self-employed Individual (unincorporated)	❑ Self-employed Individual (incorporated)
❑ Partnership	❑ Professional Association	❑ Professional Corporation (for profit)
❑ Professional Corporation (non-profit)	❑ Employee of _____ (give name of employer)	❑ Other (Describe) _____

e. In addition to Acupuncture, do you have other professional specialties? Please describe below:

_____

f. Date established: _____ / ____

g. Please state sources and amounts of total gross annual revenue:

Source of revenue	Amount last 12 months	Amount next 12 months
_____	_____	_____
_____	_____	_____

h. If you practice **other than** as an **employee** OR an **unincorporated solo practitioner, specify**:

(i) Formal business, corporate or partnership name: _____

(ii) List the names of all partners or members of your professional association/corporation who provide professional services: _____

_____

Attach a copy of your letterhead.

i. Are you associated with or do you work for a physician or surgeon? ❑ Yes ❑ No

If yes, please give the name and specialty of the physician: _____

j. Are you employed by an individual other than that shown in Question 1 above? ❑ Yes ❑ No
If yes, please attach an explanation, including details of your responsibilities.

k. Are you under contract to any individual or entity other than that shown in Question 1above? ❑ Yes ❑ No
If yes, please attach an explanation, including details of your responsibilities. If this contract contains a hold-harmless agreement, please attach a copy of the contract.

l. Are you employed by or under contract to any governmental entity? ❑ Yes ❑ No
If yes, please attach an explanation, including details of your responsibilities.

m. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ❑ Yes ❑ No
If yes, has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ❑ Yes ❑ No
Provide the name and title of the applicant's Privacy Officer _____

n. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)
____	_____	_____	_____	_____
____	_____	_____	_____	_____

If NONE, please attach an explanation.

o. Are you licensed in accordance with applicable state and federal regulations? ❑ Yes ❑ No
If no, please attach an explanation.

p. Does your state license or register acupuncturists? ❑ Yes ❑ No
If yes, advise license number _____ Expiration Date: _____

q. Are you NCCA certified? ❑ Yes ❑ No
If yes, please provide date of certification, certificate number, expiration date of certificate:
Date of Certification: _____ Certificate number: _____ Expiration date:_____

r. Are you currently in active military service? ❑ Yes ❑ No

s. Please describe Professional training including formal classroom education, tutorials, seminars, etc., on attached sheet, or attach a current curriculum vitae (C.V.).

2. EDUCATION:

Describe your professional training:

Institution (Name & Address)	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

3. EXPERIENCE:

Where have you practiced your profession during the last ten years:

a. Prior Experience - From: _____ To: _____ Location:_____

Practice Activity: _____

b. Prior Experience - From: _____ To: _____ Location:_____

Practice Activity: _____

c. Prior Experience - From: _____ To: _____ Location:_____

Practice Activity: _____

d. Have you ever failed any professional licensing or specialty organization examination? ❑ Yes ❑ No

If yes, please attach a detailed explanation, including dates and location.

4. YOUR PRACTICE:

a. Please give the approximate percentages of time spent in the following work locations:

_____% Administrative Office ____% Other (specify) _____

_____% Classroom _____% Outpatient Clinic

_____% Nursing Home/Assisted Living _____% Patient's Home

_____% Professional Office (specify profession) _____

b. Please indicate the approximate division of your patients or clients among:

Holistic Medicine	_____%	Obstetrical	_____%	Research or Experimental	_____%
Dental	_____%	Disability Evaluation	_____%	(describe)	_____
Drug Addicts	_____%	Pediatric	_____%		
Physician Rehab	_____%	Pain	_____%		
Psychiatric	_____%	Management (describe)	_____		

Must total 100%

c. Do you render professional services directly to patients? ❑ Yes ❑ No

If yes, please describe these services in detail and indicate whether you are supervised and by whom.

Detailed Description of Professional Services	**Percent of time Supervised**	**Qualifications of Supervisor**
_____	_____%	_____
_____	_____%	_____
_____	_____%	_____

d. Do you render professional services that do not involve contact with a patient? ❑ Yes ❑ No

If yes, please describe these services in detail. _____

_____

e. List the number of your employees and volunteers – if none, state none.

Number	Type of employees/volunteers
_____	_____
_____	_____
_____	_____

(i) Are all of the above individuals licensed in accordance with applicable state and federal regulations? ❑ Yes ❑ No

(ii) Do you supervise any individuals other than your own employees? ❑Yes ❑No

If yes, give detailed explanation of responsibilities and relationships to the entity which employs these individuals.

_____

Indicate by professions the number of individuals supervised:

Number:_____ Type of profession: _____

f. Provide number of patient or client encounters:

Type of visit	Number of visits last 12 months	Number of visits next 12 months
Clinic	_____	_____
Office	_____	_____
Other	_____	_____
Total number of visits	_____	_____

g. Do you administer any anesthesia? ❑ Yes ❑ No
If yes, please explain and indicate whether you are supervised and by whom. _____

_____

h. Do you use the National Council on Certification of Acupuncturists (NCCA) clean needle technique? ❑ Yes ❑ No
If No, do you use disposable needles? ❑ Yes ❑ No
If No, please attach details. _____
(ii) Dispense or prescribe: Drugs? ❑ Yes ❑ No
(iii) Use x-ray or imaging in treatment determination? ❑ Yes ❑ No
(iv) Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? ❑ Yes ❑ No
(v) Perform investigational or experimental research or therapy on human patients? ❑ Yes ❑ No

i. Do you compound in bulk, manufacture, wholesale oriental/herbal medicine or other nutritional substances or controlled substances? ❑ Yes ❑ No
If yes, please provide details _____

j. Do you prescribe or dispense any drugs without the countersignature of a physician? ❑ Yes ❑ No
If yes, please provide a detailed explanation. _____

_____

k. (i) Do you perform or assist in any surgical procedure(s)? ❑ Yes ❑ No
If yes, please answer (ii) below.
(ii) Please list ALL surgical procedures performed (including minor surgery): _____

_____
(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ❑ Yes ❑ No
If yes, please attach a detailed explanation.
(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? ❑ Yes ❑ No
If yes, please attach a detailed explanation.

l. (i) Do you perform radiation therapy? ❑ Yes ❑ No
(ii) Psychiatric shock therapy? ❑ Yes ❑ No

5. APPLICANT HISTORY (ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS)

Have you:

(i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ❑ Yes ❑ No
(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ❑ Yes ❑ No
(iii) Ever been treated for alcoholism or drug addiction? ❑ Yes ❑ No
(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ❑Yes ❑No
(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ❑ Yes ❑ No

6. Do you currently carry the following:
a. **Professional Liability Insurance**? ❑ Yes ❑ No
List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period From: MM/DD/YY	**To: MM/DD/YY**	**Insurance Company**	**Limit of Liability**	**Deductible**	**Policy Form: Claims Made or Occurrence?**	**Premium**
/ /	/ /					
/ /	/ /					

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/ /	/ /					
/ /	/ /					

If claims made, what is the **retroactive date/prior acts date** on your current policy?

b. **Commercial General Liability Insurance?** ❑ Yes ❑ No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy?

7. CLAIMS HISTORY:

a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ❑ Yes ❑ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS

IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ❑Yes ❑ No
If yes, provide full details. _____

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ❑ Yes ❑ No
If yes, fully describe the circumstances and follow up action taken: _____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING 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 SUCH VIOLATION.

*Notice applicable in most 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 conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

_____

Applicant's Signature **Title** **Date**