

Acupuncturist Application for Claims-Made Professional Liability Insurance

IMPORTANT NOTICE

You are applying for coverage under a claims-made policy. If your application is accepted, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

1. PERSONAL INFORMATION

First Name		MI	Last Name			Male	Female
Date of Birth (mm/dd/yyyy)	Place of Birth	City		State	Country		
Home Address				City	State	Zip Code	
Home Telephone Number			Alternate Telephone Number				
Principal Office Address				City	State	Zip Code	
Office Telephone Number			Office Fax Number				

E-mail Address _____ Website Address _____

2. REQUESTED COVERAGE EFFECTIVE DATE: (mm/dd/yyyy) _____

3. REQUESTED LIABILITY LIMITS Check one: Limit Per Claim / Annual Aggregate: \$500,000/\$1,500,000 \$1,000,000/\$3,000,000

4. MEMBERSHIP INFORMATION

Applicant is a member of Membership in one of your state's specialty associations is recommended – **attach a copy of your membership card.**

5. TRAINING/CONTINUING EDUCATION/LICENSES

School Attended	City	State	From	To
Other Training (acupuncture/undergraduate/graduate) City How many hours of Continuing Education Units have you taken in each of the last two years?				
Acupuncture License Number	Effective Date	State	Is it current?	
Acupuncture License Number	Effective Date	State	Is it current?	

Professional Designation:

- | | |
|---|--|
| <input type="checkbox"/> L.Ac. | <input type="checkbox"/> MD/DO |
| <input type="checkbox"/> Diplomat of Accupuncture | <input type="checkbox"/> Doctor of Oriental Medicine |
| <input type="checkbox"/> PhD. | |

6. TYPE OF PRACTICE

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Solo Practice | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Corporation | |

7. INSURANCE HISTORY (List all professional liability carriers (including current) who have insured you)

Name of Carrier _____ Name of Carrier _____

Policy Number _____ Policy Number _____

Expiration Date _____ Expiration Date _____

Please attach a current Certificate of Insurance to this application

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8. PROCEDURES

- | | | | |
|---|--|-----|----|
| a | Do you limit your practice to acupuncture as defined in your state's Business and Professions Code? | Yes | No |
| b | Do you or your employee(s) use disposable needles? | Yes | No |
| If no, please confirm that you use non-disposable needles in compliance with the statutes regarding reuse and sterilization of acupuncture needles. Attach a copy of CNT (Clean Needle Technique) certificate | | | |
| c | Do you or your employee(s) perform any procedures involving direct moxibustion?* | Yes | No |
| d | Do you or your employee(s) perform acupuncture as anesthesia for the purpose of performing surgical procedures?* | Yes | No |
| e | Do you or your employee(s) perform acupuncture during labor and delivery?* | Yes | No |

9. CLAIMS

Have you or your employee(s) ever been involved in a malpractice claim, suit or arbitration proceeding, or have you or your employees reported any incidents which resulted in a claim to a former carrier? Yes No

If yes, you must complete a claim information form for each (on page 3).

10. GOVERNMENTAL ACTION

- | | | | |
|---|---|-----|----|
| a | Have you or your employee(s) ever been investigated as the subject of, charged with, or convicted of a misdemeanor or felony? | Yes | No |
| b | Have you or your employee(s) ever entered a "no contest" plea to a crime, other than a traffic violation? | Yes | No |
| c | Have you or your employee(s) ever been investigated by any state or federal regulatory body? | Yes | No |
| d | Has any governmental agency ever suspended, revoked, restricted, placed you/your employee(s) on probation, or taken any other action against your license or your employee's license? | Yes | No |

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CLAIM INFORMATION FORM

:
Last Name of Patient/Claimant

Gender

Age

1. Condition and diagnosis of patient prior to treatment
2. Date(s) and type of treatment rendered by you
3. Condition of patient subsequent to treatment by you:
4. Nature of allegation
5. Was a suit ever filed against you? If yes, was it served? Yes When?
6. Names of other practitioners, if any, involved
7. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.
MAKE ADDITIONAL COPIES AS NEEDED