Mack Specialty Brokerage

Acupuncture Professional & General Liability Application

Mack Specialty Brokerage
7379 Pearl Rd. Suite 6
Cleveland, OH 44130-4808
Phone: (440) 268-0200
Fax: (440) 268-0202
www.mackspecialty.com

1. Name of Applicant: _____

2. Applicant is:
   a) Individual ? Employee ? Sole Practitioner
   b) Business ? Sole Proprietor ? Partnership ? Corporation
   Other Describe: _____

3. Mailing Address: _____
   Business location if different: _____
   Contact person's name: _____ Phone #: _____
   List memberships in professional organizations: _____

4. Proposed Effective Date: _____ Years in business: _____

5. Desired Limit of Professional Liability: $_____ per incident; $_____ aggregate
   If General Liability also desired: ___No $_____ occurrence; $_____ aggregate

6. Indicate the number of applicant's employees below: Number of Employees

   a) Acupuncturists: ____ Full-time ____ Part-time
   b) Acupuncture assistants: ____ Full-time ____ Part-time
   c) Clerical staff: ____ Full-time ____ Part-time
   d) Other. Describe: _____ ____ Full-time ____ Part-time
   {This policy does not contemplate student or intern exposures. Schools or instructors apply separately for this coverage.}

7. Please indicate the total number of patient visits: a) Current year:
   b) Estimated next year:

8. Annual Total Gross Receipts: Estimated next twelve months - $_____
   Last twelve months - $_____

9. Please check each type treatment used by applicant:
   Acupuncture _____
   Electro-acupuncture (or TENS) _____
   Moxibustion _____
   Acupressure _____
   Herbal Therapy _____ (Herbal Medicine Receipts $_____)
   Cold Laser _____
   Other, Describe: _____

10. Does the applicant provide nonprescription herbal medicines, vitamins, foods, food supplements or any other products? Yes __ No __

11. Does the applicant practice under the direction/supervision of a licensed physician (M.D. or D.O.) ? Yes __ No __
    If yes, please give name and address of each physician: _____

12. Does the applicant use Informed Consent forms with all clients prior to instituting treatment?

Yes __ No __

13. Does the applicant use parental consent forms prior to treating all minors? Yes __ No __

14. Does the applicant provide after care instructions to all clients (or parent/legal guardian in the event of a minor) after each treatment? Yes __ No __

15. Does the applicant use only disposable needles? Yes __ No __
If no, describe method of sterilization?_____

16. Does the applicant sterilize the needle applicators? Yes __ No __

17. Before initiating treatment, does the applicant advise all clients (or parent/legal guardian in the event of a minor) to consult a physician? Yes __ No __

If yes, it this acknowledgement obtained in writing from all clients (or parent/legal guardian in the event of a minor) prior to initiating treatment? Yes __ No __

18. After six months of treatment does the applicant advise the client (or parent/legal guardian in the event of a minor) to consult a physician prior to continuing treatment? Yes __ No __

If yes, it this acknowledgement obtained in writing from all clients (or parent/legal guardian in the event of a minor) to continuing treatment? Yes __ No __

19. Does applicant advertise its professional services in any manner other than listing in the telephone directory? Yes __ No __

If yes, please attach copies of all current advertisements.

20. Have any claims every been made or suit brought against applicant or any of applicant's employees because of any alleged malpractice, error, mistake, or premises accidents arising in any manner out of your operation? Yes __ No __
If yes, list dates:_____
Brief description:_____
_____
_____

21. Is applicant aware of any circumstance which may result in a liability claim or suit being made or brought against you or any of your employees? Yes __ No __
If yes, please give details:_____
_____

22. Does applicant enter into contractual agreements relating to professional services? Yes __ No __

If yes, please enclose copies of all such contracts.

23. Does applicant sell any products other than those customarily provided in association with applicant's professional services? Yes __ No __
If yes, please list the products provided: _____
_____

24. Is applicant licensed, registered or certified to practice any health related profession other than that of an acupuncturist? Yes __ No __
If yes, please state such health related profession:_____
_____

25. Is applicant affiliated with or associated with any health care professional person, other than acupuncturists or acupuncture assistants as stated in this application? Yes __ No __
If yes, please list such health care professionals: _____
_____

26. Does applicant provide more than 25% of professional services away from applicant's professional offices? Yes __ No __

If yes, please state percentage and locations of such professional services:_____

_____

27. Is applicant a proprietor, superintendent, officer, director, stockholder or member of the board of directors, trustees or governors of any hospital, sanitarium, clinic with or without bed and board facilities nursing home, laboratory or other business enterprise, OTHER THAN ANY BUSINESS ENTERPRISE NAMED IN QUESTION #1 ABOVE. Yes __ No __

28. Has applicant or any of applicant's employees ever been the subject of disciplinary or investigative proceedings or been reprimanded by a government or administrative agency, hospital or professional association? Yes __ No __
If yes, please explain:_____

_____

_____

29. Has applicant or any of applicant's employees ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? Yes __ No __
If yes, please explain: _____

_____

30. Has applicant or any of applicant's employees been treated for alcoholism or drug addiction? Yes __ No __
If yes, please state nature of treatment and whether applicant or applicant's employee is currently being treated: _____

_____

31. Has applicant or any of applicant's employees ever had any state health care related professional license, certificate or registration refused, suspended, revoked, or had the renewal refused or accepted only on special terms? Yes __ No __
If yes, please explain circumstances and dates: _____

_____

32. Has applicant ore any of applicant's employees ever voluntarily surrendered any state health care related professional license, certificate of registration? Yes __ No __
If yes, please explain circumstances and dates: _____

_____

ATTACH COPY OF YOUR CERTIFICATE, LICENSE, DIPLOMA OR SIMILAR DOCUMENT

33. Has applicant or any of applicant's employees ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? Yes __ No __
If yes, please explain circumstances: _____

_____

34. Please list previous medical malpractice insurance carried for the last three years:

Insurance Company	Limits	Deductible	Premium	Term

If your current or previous medical malpractice insurance was on a "claims made" basis, what is the retroactive date of coverage?_____

35. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? Yes __ No __
If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary)._____

_____

_____

36. Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?

Yes __ No __

If yes, describe the event and indicate the reason for anticipation of a claim. _____

_____

_____

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IF YOU DESIRE THE OPTIONAL GENERAL (PREMISES) LIABILITY POLICY COVERAGE, PLEASE COMPLETE QUESTIONS 37 THROUGH 39:

37. Please indicate the total square footage for each of your office premises:

Location (1):_____ Square Feet_____
Location (2):_____ Square Feet_____
Location (3):_____ Square Feet_____

38. Is applicant's occupancy of the above premises other than that of a tenant? Yes __ No __
If yes, please explain:_____

39. Does the applicant have any other premises or operations which are subject to exposure which are not stated in this application? Yes __ No __

If yes, please describe premises or operations completely:_____

_____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

_____ _____

Date Applicant/Title