



# Acupuncturist Professional Liability Insurance Application Claims-Made Form

**YES!** I want Acupuncturist Professional Liability Insurance with limits up to \$1,000,000 per claim, up to \$3,000,000 aggregate. (Limits other than \$1,000,000/\$3,000,000 are available, please call 1-800-567-4043)

## A. GENERAL INFORMATION

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Please answer ALL questions and SIGN and DATE this form. Incomplete request cannot be processed.

1. Name: \_\_\_\_\_ Social Security: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City: \_\_\_\_\_ Day Telephone #: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Night Telephone #: \_\_\_\_\_  
 County: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

## B. PRACTICE INFORMATION

### 2a. I primarily work in/at (choose one):

- Comm. Health Facility (02)   
  Hospice (06)   
  Outpatient Facility (16)   
  School/Health Dept. (11)  
 Correctional Facility (10)   
  Hospital- In Patient Unit (31)   
  Primary Physician Clinic (32)   
  Speciality Physician Clinic (33)  
 Home Health (05)   
  Nursing Home/LTC (08)   
  Psychiatric Facility (28)  
 Other (15) \_\_\_\_\_

### 2b. Employment Status: (Please check only one box:)

**Please note:** *Employed* is defined as providing services on behalf of an entity you do not own, and receiving a W-2 form from your employer. *Self-employed* is defined as providing services as an independent contractor and paying self-employment taxes using a 1099 form. If you are incorporated with or without employees, please call 1-888-288-3534.

- Employed**, defined as providing services on behalf of an entity you do not own, and receiving a W-2 Form from your employer.  
 If you are employed, please provide the following:  
**Name of employer:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_  
 **Self-employed (not incorporated)**, defined as providing services as an independent contractor and paying self-employment taxes using a 1099 Form.

- 2c.**  Full-time (check only if total hours worked is greater than 24 hours per week)  
 Part-time (check only if total hours worked does not exceed 24 hours per week; eligible for 50% discount off the full-time rate)  
 Student (check only if student in accredited Acupuncture program. Students are **written** on occurrence form.)

- 2d.** Are you a medical physician or osteopathic physician?.....  Yes  No  
 Do you hold any other licenses or certifications? (other than Acupuncture).....  Yes  No  
 If yes, please name: \_\_\_\_\_

### 2e. Professional education or training:

1. Name of institution where you received your Acupuncture training: \_\_\_\_\_  
 2. City: \_\_\_\_\_ 3. State: \_\_\_\_\_ 4. Date graduated: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 5. Are you licensed or certified to perform Acupuncture?.....  Yes  No

6. Are you credentialed by the NCCAOM?.....  Yes  No

7. Type of Certification \_\_\_\_\_

8. Year that you began your practice of Acupuncture: \_\_\_\_\_

2f. Are you a member of an Acupuncturist Association?.....  Yes  No

If yes, what state(s): \_\_\_\_\_

2g. Are you a member of the American Association of Acupuncture and Oriental Medicine (AAAOM)?.....  Yes  No

If yes, Current Member #: \_\_\_\_\_

Other Associations: \_\_\_\_\_

2h. I agree to conduct an informed consent discussion with each patient prior to treatment, and retain a signed consent form, treatment plan and treatment progress notes in each patient's health information record.....  Yes  No

2i. I only use stainless steel needles which are disposed after each use following appropriate medical waste disposal guidelines.....  Yes  No

I have reviewed the List of Exclusions on page 5 and certify I do not perform any of the listed treatments, procedures or therapies.....  Yes  No

**C. COVERAGE INFORMATION**

3. Do you need Prior Acts Coverage? (If so, you must provide the Retro Date of your current policy, found on the Declarations Page. For important details on Retro Date, see "Important Notice About Claims-Made Coverage" on Page 3.)

Yes, I need Prior Acts Coverage. My Retro Date is: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(If requesting Prior Acts, please include a copy of your Declarations Page and a copy of your claim loss data from your current insurance carrier.)

No, I do not need Prior Acts Coverage. I have read and understand "Important Notice About Claims-Made Coverage" on Page 3.

4. Requested Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Must be within 60 days from the date we receive your application. If date indicated is prior to receipt date or if not filled out, the effective date will be the receipt date.)  
MONTH DAY YEAR

5. Have you ever had professional liability insurance declined, canceled or non-renewed for any reason other than for non-payment of premium? (Not applicable for MO residents).....  Yes  No

6. Has any claim or lawsuit for malpractice ever been brought against you or are you aware of any incidents that may result in a claim or lawsuit?.....  Yes  No

7. Within the last 5 years, have you been the subject of complaints, charges, or disciplinary action against you for any reason, by a court, licensing board or regulatory agency responsible for maintaining the standards of your profession?.....  Yes  No

(If you have answered "yes" to questions 5, 6 or 7, please provide complete details on a separate sheet of paper and attach to application.)

**Insurance Agent: Michael J. Loughran Iowa License #IA241616; Florida License #A158896**

## AN IMPORTANT NOTICE ABOUT CLAIMS-MADE COVERAGE - PLEASE READ

If you are currently insured under a claims-made policy, it is important that you continue your coverage without interruption when moving to a new policy. By providing HPSO with the Retroactive Date or "Retro Date" of your expiring policy, upon approval of your application, your new policy will provide you with continuous coverage. This means that any claim that might occur on or after your Retro Date will be covered under your new policy.

If you do not provide your current Retro Date on this application, and do not elect to purchase Extended Reporting Period coverage from your former insurer ("tail coverage"), your previous claims-made coverage will lapse. It will no longer respond to any claims that may arise for that original policy period -- and neither will your new policy. This could leave you completely unprotected or "bare".

## DETERMINING YOUR RATES

Rates for a claims-made policy increase automatically over a number of years to reflect accumulating risk, until they reach a maximum or "maturity." **If you are newly licensed or you are currently insured under an occurrence policy**, you would pay the premium appropriate for your class listed under the "Year 1" column in the chart on Page 4. Include a mandatory \$2.00 HPSO Purchasing Group Membership Fee. You do not need to enter a Retro Date because it will be the same as your effective date.

**If you have been insured under a claims-made policy and wish to continue your coverage without interruption**, you must include a copy of your current Declarations Page with this application. Please enter the Retro Date of your current policy (found on the Declarations Page), and the requested effective date of your new policy, on this application where indicated. To determine the appropriate rate, first note the number of years that have lapsed between the dates you provided on Page 2. Fractional years of six months or more are rounded UP; less than six months rounded to the next lower year. Once you have calculated the correct number of years, add 1 to this total to represent the current year, and this number is the basis for your coverage. If the total is 5 years or more, you would pay the "Mature" rate listed on the chart on Page 4. Totals of less than 5 years pay the appropriate premium listed in the matching column.

If you do not require Prior Acts coverage, please check the appropriate box on question 4 of this application. If you have any questions or need help with this application, or if you would like information on Prior Acts coverage for services performed before the effective date of this policy, please call 1-888-273-4686 for assistance.

## OPTIONAL GENERAL LIABILITY RATES

The professional liability insurance policy you are applying for includes Workplace Liability coverage. Workplace Liability is similar to General Liability in that it protects your business for "non-medical" incidents that result in injury or damage. However, the limit of liability for workplace incidents is shared with your professional liability coverage limit.

The **benefit** of having General Liability is that it provides a separate \$1 million limit of coverage in addition to your professional liability limit and provides you with more comprehensive protection.

If leasing or renting, General Liability may be required by contract with your landlord. Check any contracts you have signed for an insurance clause to make sure that you are complying with any requirements to carry a separate limit of liability. If you have any questions on General Liability, please call **1-800-567-4043**.

Yes, I would like to include the optional General Liability coverage. Premium for primary practice: (a) \_\_\_\_\_ \$150.00 \_\_\_\_\_

Primary Practice Location: Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Number of additional Practice Locations (please list below) \_\_\_\_\_ (indicate #) x \$50.00 = (b) \_\_\_\_\_

### General Liability Total due (a+b)

( There is an additional charge for this coverage pending underwriter approval. Rate may vary due to additional location or higher limit request.)  
If there are additional practice locations, complete the selection below and attach a separate sheet if necessary.

	Additional Practice Locations -- Addresses	Own or Lease?
1.		
2.		
3.		

**8. PROFESSIONAL LIABILITY RATES FOR CLAIMS-MADE POLICY FORM (LIMITS OF \$1,000,000/\$3,000,000)**

All states excluding (CA, FL, NY)	Year 1	Year 2	Year 3	Year 4	Mature
Full-time Professional (Employed & Self Employed)	\$247	\$440	\$594	\$648	\$764
Part-time Professional (Employed & Self Employed)	\$124	\$220	\$297	\$324	\$382
Student	N/A	N/A	N/A	N/A	\$150

  

California	Year 1	Year 2	Year 3	Year 4	Mature
Full-time Professional (Employed & Self Employed)	\$231	\$412	\$557	\$608	\$715
Part-time Professional (Employed & Self Employed)	\$116	\$206	\$279	\$304	\$358
Student	N/A	N/A	N/A	N/A	\$161

  

New York	Year 1	Year 2	Year 3	Year 4	Mature
Full-time Professional (Employed & Self Employed)	\$247	\$440	\$594	\$649	\$764
Part-time Professional (Employed & Self Employed)	\$124	\$220	\$297	\$325	\$382
Student	N/A	N/A	N/A	N/A	\$150

Florida Residents please call 1-800-567-4043 for more information.

**PAYMENT OPTIONS:**

**Payment Options\*:**  Charge my credit card:  AMEX  Visa  MasterCard  Discover  
 Enclosed is my check. (Payable to: HPSO) Card #: \_\_\_\_\_ Expiration Date: \_\_\_ / \_\_\_ / \_\_\_

\*All applicants must add a Healthcare Providers Service Organization Purchasing Group Membership Fee (\$2.00) Residents of FL, KY, NJ and WV must first add a state mandated surcharge to your base premium (FL: 0.85%, KY 1.8%, NJ: 0.70%, WV: 0.55%). To calculate your total amount due, please add your base premium, state surcharge (if applicable) & membership fee. If you are paying by credit card, your card will be charged as detailed above.

I have answered these questions to the best of my knowledge. I certify that I hold the highest credentials or standards appropriate for the healthcare profession for which I have applied as mandated by my state guidelines. I have not withheld information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete this insurance. It is agreed that this Application shall be on file with the Company and that it shall be deemed to be attached to and made part of the policy, if issued, as if physically attached to the policy. I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my insurance coverage. This application will be the basis of the contract should a Certificate of Insurance be issued. I understand the state mandated surcharge will be added to my annual premium if I am a resident of FL (0.85%), KY (1.8%), NJ (0.70%) or WV (0.55%). I have read and consent to the compensation terms on page 5.

**FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE**

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to civil fines and criminal penalties (For District of Columbia residents only: 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.) (For Florida residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) (For Louisiana residents only: 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.) (For Maine residents only: 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 a denial of insurance benefits.) (For Maryland residents only: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) (For New York residents only: 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.) (For Oklahoma residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) (For Pennsylvania residents only: 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 subjects such person to criminal and civil penalties.) (For Tennessee and Washington residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.)

Please Print Name \_\_\_\_\_  
 Applicant Signature **X** \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_  
 This application must be fully completed, signed and dated in ink. We will issue your certificate of insurance upon approval.  
 You may fax the completed application to 1-800-701-1986 or mail it to HPSO, 159 E. County Line Road, Hatboro PA 19040-1218

This program is underwritten by American Casualty Company of Reading, Pennsylvania, a CNA company, and is offered through the Healthcare Providers Service Organization Purchasing Group. Coverages, rates and limits may differ or may not be available in all states. All products and services are subject to change without notice. CNA is a registered trademark of CNA Financial Corporation. Copyright © 2014 CNA. All rights reserved. Healthcare Providers Service Organization is a registered trade name of Affinity Insurance Services, Inc.; (AR 244489); in CA, MN & OK, AIS Affinity Insurance Agency, Inc. (CA 0795465); in CA, Aon Affinity Insurance Services, Inc., (0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY and NH, AIS Affinity Insurance Agency.



# Acupuncturist Professional Liability Insurance Application- Claims-Made Form

(This policy does **NOT** cover the following procedures, treatments or therapies)

## EXCLUSIONS

- Acupuncture as anesthesia during surgical procedures
- Chiropractic manipulation and/or adjustment
- Use of Cold Laser
- Colonic irrigations
- Dehydration of hemorrhoids
- Direct Moxibustion
- Fever Therapy
- Gemstone therapy
- Use of reusable needles
- Use of Toftness device
- Treatment of animals
- Treatment or reduction of a fracture
- X-ray, microwave and radium
- Maibotsushin/Okibari or any prolonged insertion of needles (ear tacs or seeds are acceptable)
- Obstetrics including the care and treatment of woman during pregnancy and childbirth, and infants less than fourteen days old.
- Fertility, contraception, or infertility.
- Any service, treatment, advice or instruction for the purpose of skin or appearance enhancement, personal grooming, cosmetic procedures and salon or spa services including Botox or its homeopathic equivalent or any fluid injection
- Treatment of cancer, epilepsy, or acquired immune deficiency syndrome, except that treatment is not excluded if such treatment is solely to alleviate pain and during the entire period of treatment, the patient is under the care of a licensed physician for the condition or disease and you do not interfere with the course of treatment recommended by such patient's treating physician.

## COMPENSATION and OTHER DISCLOSURE INFORMATION

Healthcare Providers Service Organization (HPSO), a division of Affinity Insurance Services, Inc., exclusively offers the HPSO Program as an agent of CNA and provides services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

Affinity Insurance Services Inc. is an insurance producer licensed in your state. Insurance producers are authorized by their license to confer with insurance purchasers about the benefits, terms and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction involves one or more of these activities. Compensation will be paid to the producer, based on the insurance contract the producer sells. Depending on the insurer(s) and insurance contract(s) the purchaser selects, compensation will be paid by the insurer(s) selling the insurance contract or by another third party. Such compensation may vary depending on a number of factors, including the insurance contract(s) and the insurer(s) the purchaser selects. In addition, Affinity may charge a fee for administrative services. Your signature on your application, quote form, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Aon. The insurance purchaser may obtain information about compensation expected to be received by the producer based in whole or in part on the sale of insurance to the purchaser, and compensation expected to be received based in whole or in part on any alternative quotes presented to the purchaser by the producer, by calling 1-800-567-4043.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. When they exist, these investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon web site at [http://www.aon.com/market\\_relationships](http://www.aon.com/market_relationships) for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interest.

## CONTRACTS AND AGREEMENTS

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit [http://www.aon.com/market\\_relationships](http://www.aon.com/market_relationships) for more detail on these agreements.