KINSALE INSURANCE

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Kinsale Insurance Company
P.O. Box 17008
Richmond, VA 23236
(804) 289-1300
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CHIROPRACTOR NEW BUSINESS APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.

If a question is not applicable, then state "N/A".

The following information must be submitted with the completed application:

- Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
- Copy of your Curriculum Vitae
- Copy of all licenses and board certifications
- Copy of your business letterhead
- Copy of all advertising that you use
- Copy of all reporting endorsements previously issued to you
- 5-year company loss runs, valued within the last 60 days

PERSONAL INFORMATION

Applicant's Name and Degree designation(s): _____

Social Security Number: _____ - _____ - _____ Date of Birth _____ / _____ / _____

Mailing Address: _____
STREET CITY COUNTY STATE ZIP

Practice Address: _____
STREET CITY COUNTY STATE ZIP

E-Mail Address: _____ Website Address: _____

Are you a U.S. Citizen? ☐ Yes ☐ No If no, indicated status and date of entry _____

PRACTICE SPECIALTY AND EDUCATION

1. License Information
   a. Chiropractic License Number(s): _____
   b. State(s) Licensed: _____
   c. Are you licensed to practice any other health care practices? ☐ YES ☐ NO

   If yes, please circle: MD DO DPM ND RN RPT LAC MIDWIFE Other: _____

2. Education: _____ _____
   Chiropractor College or University, City, State, County Year of Graduation

3. List all locations and dates where you have practiced in the last 10 years:

Practice Name	City/State	From	To

4. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy? If yes,
   a. Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? ☐ YES ☐ NO
   b. Provide the name and title of the Applicant's Privacy Officer: _____

PRACTICE INFORMATION

5. Please describe your practice:

☐ Sole Proprietorship (unincorporated) _____

☐ Professional Corporation _____Applicant's % Ownership: _____%

☐ Employee, Associate, or Independent Contractor with _____

6. Are you requesting that the entity be named on your policy? If yes, please forward articles of incorporation. ☐ YES ☐ NO
7. Please tell us how many
   a. Hours per week you practice chiropractic: _____
   b. Patient visits you handle annually: _____
8. Approximate gross annual income from your practice

☐ Less than $50,000 ☐ $100,000 - $149,999 ☐ $200,000 or more
☐ $50,000 - $99,999 ☐ $150,000 - $199,999

9. Do you anticipate any changes in your practice in the next 12 months? *If yes, please attach details* ☐ YES ☐ NO

SPECIFICS OF PRACTICE/PROCEDURES

10. Please indicate those procedures or devices used in your practice:

	Yes	No		Yes	No
General meric adjusting	☐	☐	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	☐	☐	Treat cancer	☐	☐
Activator	☐	☐	Treat epilepsy	☐	☐
Galvanci	☐	☐	Manipulation under anesthesia	☐	☐
Ultraviolet	☐	☐	Prenatal care & normal deliveries	☐	☐
Ultrasound	☐	☐			

11. If the answer to any of the questions below is "no," please attach details. Do you:

a. 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 months? *If no, please describe how you assess vascular flow.* ☐ YES ☐ NO

If an unusual finding results, do you refer the patient to the appropriate medical practitioner? ..... ☐ YES ☐ NO

b. Make a differential diagnosis? ..... ☐ YES ☐ NO

c. Always record the patient's account of his/her progress? ..... ☐ YES ☐ NO

d. Always record objective findings? ..... ☐ YES ☐ NO

e. Always record details of treatment procedures? ..... ☐ YES ☐ NO

12. If the answer to any of the questions below is "yes," please attach details. Do you:

a. Perform acupuncture? ..... ☐ YES ☐ NO

If yes, do you use the National Council on Certification of Acupuncturists (NCCA) clean needle technique? ..... ☐ YES ☐ NO

Date of last NCCA exam taken and passed _____

If no, do you use disposal needles? *(If no, please attach details)* ..... ☐ YES ☐ NO

b. Dispense or prescribe: Drugs? ..... ☐ YES ☐ NO

Vitamins? ..... ☐ YES ☐ NO

c. Use x-ray or imaging in treatment determination? ..... ☐ YES ☐ NO

d. Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? ..... ☐ YES ☐ NO

e. Perform investigation or experimental research or therapy on human patients? ..... ☐ YES ☐ NO

f. Perform animal chiropractic? ..... ☐ YES ☐ NO

STAFF

13. Please indicate the number of professional employees, volunteers and independent contractors (not including yourself).

	# of Employees and Volunteers	**# of Independent Contractors**
Chiropractor	_____	_____
Chiropractor Assistant	_____	_____
Nurses, Licensed Practical	_____	_____
Nurses, Practitioner	_____	_____
Nurses, Registered	_____	_____
X-ray Technician	_____	_____
Laboratory Technician	_____	_____
Physical Therapist	_____	_____
Massage Therapist	_____	_____
Student/preceptors	_____	_____
Other _____	_____	_____

NOTE: If you require any of the above to be Named Insureds, please submit a separate application for each individual.

14. Are all the above individuals licensed in accordance with applicable state and federal regulations? *If no, please attach explanation.* ☐ YES ☐ NO

15. Are you engaged in any business other than the practice of chiropractic? ☐ YES ☐ NO
If yes, please attach details.

16. Do you own (wholly or in part), operate or administer any hospital, nursing home, surgi-center, clinic or other facility where healthcare services are customarily rendered? ☐ YES ☐ NO

17. Do you, or the entity named in Question 5, contract to provide professional services to any individual, entity or governmental entity? *If yes, please attach details.* ☐ YES ☐ NO

18. Are you affiliated with any hospitals? *If yes, please provide name(s), city, state* ☐ YES ☐ NO

19. Please list any professional societies/organizations in which you are currently a member: _____
_____

PRIOR POLICY AND LOSS INFORMATION – Questions 20-34 provide details for all "YES" answers

20. Has your medical or narcotics license ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? ☐ YES ☐ NO

21. Has your board certification or membership in any medical society or association ever been refused, suspended, revoked, or voluntarily surrendered? ☐ YES ☐ NO

22. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? ☐ YES ☐ NO

23. Have you ever been charged with, or convicted of a crime other than minor traffic violations? ☐ YES ☐ NO

24. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? ☐ YES ☐ NO

25. Has any fee or professional relations complaints been registered against you with your medical association, hospital, or a state licensing authority? ☐ YES ☐ NO

26. Provide the following information pertaining to your past 5 years of professional liability insurance coverage:

Carrier	Policy Period	Policy Limits	Deductible	Claims Made? (Y/N)	Retro Date

27. Have you ever practiced without professional liability insurance? ☐ YES ☐ NO

28. Do you have professional liability insurance for work you do elsewhere? If yes, please explain on page 5. ☐ YES ☐ NO

29. Have you ever had any insurance company decline, cancel, rescind, or non-renew any professional liability insurance policy? ☐ YES ☐ NO

30. Have you ever been involved in any professional liability claim or suit, either directly or indirectly? ☐ YES ☐ NO

31. Are you aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? ☐ YES ☐ NO

32. Are you aware of any request for medical records by a patient or his/her attorney which might result in a claim? ☐ YES ☐ NO

33. Are you aware of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission, or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result notice, or attorney contact? ☐ YES ☐ NO

34. Have all circumstances that might reasonably lead to a claim or suit, even if you believe them to be without merit, been reported to your current or prior professional liability company? **Indicate N/A if you are not aware of any such circumstances** . If yes, how many? ____ please complete a supplemental claims form for each. ☐ YES ☐ NO ☐ N/A

REQUESTED COVERAGE

(NOTE: The Company may not offer or quote requested coverage)

Requested Effective Date:_____ Requested Retroactive Date:_____

Requested Limits of Liability

- ☐ $100,000/$300,000
- ☐ $200,000/$600,000
- ☐ $250,000/$750,000
- ☐ $500,000/$1,500,000
- ☐ $1,000,000/$3,000,000
- ☐ $2,000,000/ $6,000,000 (VA only)

Requested Deductible

- ☐ $5,000
- ☐ $7,500
- ☐ $10,000
- ☐ $25,000
- ☐ $50,000
- ☐ Other $_____

SUPPLEMENTAL INFORMATION

Use this page to as needed to address questions referenced within the application or to provide information you deem pertinent to our review of your application

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

• I have no known losses or claimsthat have not been reported to my prior insurance carrier or any other source from which payment might be made;

• I have no knowledgeof acts, omissions or circumstances that relate to a professional service which could reasonably result in a claim, that has not been reported to a prior insurance carrier;

• I have no knowledgeof any request for medical records by a patient or their attorney which might result in a claim;

• I have no knowledgeor information relating to service or services on a Board which might result in a claim; and

• I have no knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result, or attorney contact.

My signature on page 9 below confirms the above statements unless otherwise noted

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 fact.

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: _____

Applicants Signature: _____ Date: _____

Agent/Broker Name: _____

SUPPLEMENTAL CLAIM/ INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient:_____ Age:_____ Sex:_____

Incident ☐ Claim ☐

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient?_____

_____

STATUS OF CLAIM

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor
☐ Suit settled out of court
Date claim paid: _____
Amount paid: $_____
Did you want to settle? ☐ Yes ☐ No

Court outcome in YOUR favor:
☐ Jury verdict
☐ Directed verdict

Court outcome in favor of plaintiff:
☐ Jury verdict
☐ Directed verdict
Amount of loss payment: $_____

Unresolved/Open
☐ Awaiting mediation
☐ Awaiting court action
Reserve amount: $_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

_____

Signature: _____ Date:_____

Printed Name: _____

Return to **Submit@bsrins.com**