



2. APPLICANT PRACTICE

- a. Where have you practiced your profession since graduation?
- (i) In _____ State (ii) In _____ State
- (iii) In _____ State (iv) In _____ State
- b. Please check one box describing your practice and fill in the blanks using an attached sheet, if necessary.
- (i) Sole proprietorship (unincorporated) _____
Business Name
- (ii) Professional corporation _____
Corporate Name
Do you want corporate coverage? Yes No.
- (iii) Partnership _____
Partners' Names Partnership Names
- (iv) Employee, associate or independent contractor with _____
Employer's Name
- c. Please tell us how many
- (i) Hours per week you practice chiropractic: _____
- (ii) Patient visits you handle annually: _____
- d. Approximate gross annual income from your practice
- Less than \$50,000 \$100,000 - \$149,999 \$200,000 or more
- \$50,000 to \$99,999 \$150,000 - \$199,999
- e. Do you anticipate any changes in your practice in the next 12 months? Yes No
If Yes, please attach details.

3. PROCEDURES

- a. Please indicate those procedures or devices used in your practice:
- | | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> |
|-------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| (i) General merric adjusting | <input type="checkbox"/> | <input type="checkbox"/> | (xvi) Massages | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Upper cervical specific | <input type="checkbox"/> | <input type="checkbox"/> | (xvii) Short wave diathermy | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Instrumental adjusting | <input type="checkbox"/> | <input type="checkbox"/> | (xviii) Kinesiology | <input type="checkbox"/> | <input type="checkbox"/> |
| (iv) Gonstead/diversified | <input type="checkbox"/> | <input type="checkbox"/> | (xix) Mechanical traction | <input type="checkbox"/> | <input type="checkbox"/> |
| (v) Direct non-force | <input type="checkbox"/> | <input type="checkbox"/> | (xx) Whirlpool | <input type="checkbox"/> | <input type="checkbox"/> |
| (vi) Sacro-occipital | <input type="checkbox"/> | <input type="checkbox"/> | (xxi) Stressology | <input type="checkbox"/> | <input type="checkbox"/> |
| (vii) Hydroculator/heat packs | <input type="checkbox"/> | <input type="checkbox"/> | (xxii) Internal coccyx adjustment | <input type="checkbox"/> | <input type="checkbox"/> |
| (viii) Electrical stimulation | <input type="checkbox"/> | <input type="checkbox"/> | (xxiii) Gemstone therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| (ix) Ice-cryotherapy | <input type="checkbox"/> | <input type="checkbox"/> | (xxiv) Toftness device | <input type="checkbox"/> | <input type="checkbox"/> |
| (x) Trigger point | <input type="checkbox"/> | <input type="checkbox"/> | (xxv) Colonic irrigations | <input type="checkbox"/> | <input type="checkbox"/> |
| (xi) Cold laser | <input type="checkbox"/> | <input type="checkbox"/> | (xxvi) Treat cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| (xii) Activator | <input type="checkbox"/> | <input type="checkbox"/> | (xxvii) Treat epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| (xiii) Galvanic | <input type="checkbox"/> | <input type="checkbox"/> | (xxviii) Manipulation under anesthesia | <input type="checkbox"/> | <input type="checkbox"/> |
| (xiv) Ultraviolet | <input type="checkbox"/> | <input type="checkbox"/> | (xxx) Prenatal care & normal deliveries | <input type="checkbox"/> | <input type="checkbox"/> |
| (xv) Ultrasound | <input type="checkbox"/> | <input type="checkbox"/> | | | |
- b. If the answer to any of the questions below is No, please attach details. Do you:
- (i) 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? [] Yes [] No
If No, please describe how you assess vascular flow.

If an unusual finding results, do you refer the patient to the appropriate medical practitioner? [] Yes [] No

- (ii) Make a differential diagnosis?..... [] Yes [] No
- (iii) Always record the patient's account of his/her progress? [] Yes [] No
- (iv) Always record objective findings? [] Yes [] No
- (v) Always record details of treatment procedures? [] Yes [] No

c. If the answer to any of the questions below is YES, please attach details. Do you:

- (i) Use acupuncture? [] Yes [] No
If Yes, do you use the National Council on Certification of Acupuncturists (NCCA)
clean needle technique? [] Yes [] No
Date last NCCA exam taken and passed. _____
If No, do you use disposal needle? [] Yes [] No
If No, please attach details.
- (ii) Dispense or prescribe: Drugs?..... [] Yes [] No
Vitamins? [] 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

4. APPLICANT OPERATIONS

- a. (i) Do you use a collection agency? [] Yes [] No
If Yes, please give name of agency _____
- (ii) Has the agency authority to file a collection suit at its discretion? [] Yes [] No
- b. (i) Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)?
[] Yes [] No
- (ii) Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of,
patients? [] Yes [] No If yes, please attach details and submit copy of ALL advertisements.

5. STAFF

a. Please indicate the number of professional employees, volunteers and independent contractors (IF NONE, STATE NONE).

| | No. of Employees and Volunteers | No. of Independent Contractors |
|----------------------------------|---------------------------------------|--------------------------------------|
| (i) Chiropractor | _____ | _____ |
| (ii) Chiropractor Assistant | _____ | _____ |
| (iii) Nurses, Licensed Practical | _____ | _____ |
| (iv) Nurses, Practitioner | _____ | _____ |
| (v) Nurses, Registered | _____ | _____ |
| (vi) X-ray Technician | _____ | _____ |
| (vii) Laboratory Technician | _____ | _____ |
| (viii) Physical Therapist | _____ | _____ |
| (ix) Massage Therapist | _____ | _____ |
| (x) Student /preceptors | _____ | _____ |



3001 Philadelphia Pike
Claymont, DE 19703-2580

800-365-0816
302-764-9125 facsimile
www.rockwoodinsurance.com

(xi) Other _____

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

- b. Are all the above individuals licensed in accordance with applicable state and federal regulations?[] Yes [] No
If No, please attach explanation.
- c. Are you engaged in any business other than the practice of chiropractic?[] Yes [] No
If Yes, please attach details.
- d. 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
If Yes, please attach details.
- e. Do you or the entity named in Question 2(b) contract to provide professional services to any individual, entity or governmental entity?[] Yes [] No
If Yes, please attach details.
- f. Are you affiliated with any hospitals?[] Yes [] No
If Yes, please provide name(s), city, state.
- g. Please list any professional societies/organizations in which you are currently a member:

6. APPLICANT HISTORY/CLAIMS

- a. Have you or any of your employees: (Attach detailed explanation for any Yes answers)
 - (i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a government or administrative agency, hospital or professional association? (Attach copy of Complaint and Consent Order documents, if applicable.) [] 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 or undergone personal psychiatric treatment or has any has any administrative agency, hospital or professional association requested or required evaluation an alleged mental condition and/or alcohol or drug addiction? [] Yes [] No
 - (iv) Ever had any state professional license refused, suspended, revoked, renewal refusal or accepted only on special terms or ever voluntarily surrendered same? [] Yes [] No
 - (v) Ever had any professional liability insurance canceled, declined, renewal refused or accepted only on special terms?..... [] Yes [] No
 - (vi) Ever failed any professional licensing examination?..... [] Yes [] No
 - (vii) Any chronic physical illness or defect?..... [] Yes [] No
- b. Has any claim or suit been brought against you and/or any of your employees? [] Yes [] No
If Yes, please complete a Supplemental Claim Form for each claim or suit.
- c. Are you aware of any circumstances which may result in a malpractice claim or suit against you or any of your employees? [] Yes [] No
If Yes, please complete a Supplemental Claim Form, giving details for each circumstances.
- d. Please list prior professional liability insurance for each of the past five years. IF NONE, STATE NONE.

| Insurance Carrier | Policy Number | Limits of Liability | Deductible (if any) | Premium | Inception Mo./Day/Yr. | Exp. Mo./Day/Yr. | Expiration Mo./Day/Yr. | Was this a Claims Made Policy Form? | |
|-------------------|---------------|---------------------|---------------------|---------|-----------------------|------------------|------------------------|-------------------------------------|----|
| | | | | | | | | Yes | No |
| | | | | | | | | | |



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| | | |
|-------|-----|-----|
| _____ | [] | [] |
| _____ | [] | [] |
| _____ | [] | [] |
| _____ | [] | [] |
| _____ | [] | [] |

e. If prior professional liability insurance was on a claims made basis, advise the retroactive date of coverage _____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

I AUTHORIZE any professional society, prior or present insurer, business or professional associate, licensing board, governmental entity, corporation, partnership, organization, institution or person that may have any record or knowledge concerning any claim or any of the statements and answers made herein to release such information to the underwriting manager, Company and/or affiliates thereof. I authorize the use of a copy of this authorization in place of the original.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.