

S&H Underwriters, Inc.

Send To: FAX 802-229-5669 Quotes@sh-underwriters.com

INDIVIDUAL PRACTITIONERS

(Chiropractors, Counselors, Dieticians, Nurse Practitioners, PAs, RNs, Therapists, Vets)
PROFESSIONAL AND GENERAL LIABILITY INSURANCE
(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter you are working with. For contact information please visit www.usrisk.com/healthcare.html

1. APPLICANT INFORMATION:

(unincorporated) (incorporated) Partnership Professional Association Professional Corp (for profit) Professional Corporation (non-profit) (give name of employer) Please indicate your professional specialty: Chiropractor Counselor Dietician Physician Assistant Nurse Practitioner Registered Nurse	Address:				
Contact name: Web site Address: Fax:	City:	State: Zip:	County:		
Phone: Web site Address: Fax:					
Professional degree: Place of Birth: Applicant is (check all that apply): U.S. Citizen (If not, provide status) Partnership Professional Association Professional Corporated) Professional Corporation (non-profit) Please indicate your professional specialty: Chiropractor Physician Assistant Nurse Practitioner Phespist Nurse Practitioner Phespist Date established: Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months					
Place of Birth: Applicant is (check all that apply): U.S. Citizen (If not, provide status) Partnership Professional Association (unincorporated) (professional Corporation (non-profit) Professional Corporation (give name of employer) Please indicate your professional specialty: Chiropractor Physician Assistant Nurse Practitioner Physician Assistant Nurse Practitioner Registered Nurse Therapist Date established: Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months	List all other locations (use an additional sh	eet of paper if necessary	/):		
Place of Birth: Applicant is (check all that apply): U.S. Citizen (If not, provide status) Partnership Professional Association (unincorporated) (professional Corporation (non-profit) Professional Corporation (give name of employer) Please indicate your professional specialty: Chiropractor Physician Assistant Nurse Practitioner Physician Assistant Nurse Practitioner Registered Nurse Therapist Date established: Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months	Professional degree:				
U.S. Citizen (If not, provide status) Self-employed Individual (unincorporated) (unincorporated) (unincorporated) (incorporated) (professional Association (for profit) (professional Corporation (non-profit) (give name of employer) (Describe) Please indicate your professional specialty: Chiropractor Physician Assistant Nurse Practitioner Physician Assistant Veterinarian Other (Specify) Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months					
(unincorporated) (incorporated) Partnership Professional Association Professional Corp (for profit) Professional Corporation (give name of employer) Other (non-profit) (give name of employer) Dietician Physician Assistant Nurse Practitioner Registered Nurse Therapist Veterinarian Other (Specify) Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months	. Applicant is (check all that apply):				
Professional Corporation	☐ U.S. Citizen (If not, provide status	•		Self-employed Individua (incorporated)	
(non-profit) (give name of employer) (Describe)	☐ Partnership	☐ Professional A	ssociation	Professional Corporatio (for profit)	
Please indicate your professional specialty: Chiropractor Physician Assistant Nurse Practitioner Therapist Other (Specify) Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months	·				
□ Chiropractor □ Counselor □ Dietician □ Physician Assistant □ Nurse Practitioner □ Registered Nurse □ Therapist □ Veterinarian □ Other (Specify) . Date established:/ Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months	(non-profit)	(give name of	employer)	(Describe)	
□ Physician Assistant □ Nurse Practitioner □ Registered Nurse □ Therapist □ Veterinarian □ Other (Specify) Date established: / Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months					
Therapist	·	Counselor		☐ Dietician	
Date established: / Please state sources and amounts of total gross annual revenue: Source of revenue	•			-	
Please state sources and amounts of total gross annual revenue: Source of revenue Amount last 12 months Amount next 12 months	•	Veterinaria	1	☐ Other (Specify)	
Source of revenue Amount last 12 months Amount next 12 months	. Date established:/				
	Please state sources and amounts of total g	gross annual revenue:			
If you practice other than as an employee OR an unincorporated solo practitioner, specify :	Source of revenue Amount la	st 12 months A	mount next 12 mo	onths	
If you practice other than as an employee OR an unincorporated solo practitioner, specify :					
If you practice other than as an <u>employee</u> OR an <u>unincorporated</u> solo practitioner, specify:					
	If you practice other than as an employee (OR an <u>unincorporated</u> so	lo practitioner, sp	ecify:	
(i) Formal business, corporate or partnership name:	(i) Formal business, corporate or partne	ership name:			
	services:				

Attach a copy of your letterhead.

i	. Ar		d with or do you work fo give the name and speci	or a physician or surgeon? alty of the physician:			☐ Yes ☐ No
j	. Ar	e you employed	d by an individual other	than that shown in Questincluding details of your res			☐ Yes ☐ No
ŀ	c. Ar	re you under co If yes, please a	ntract to any individual	or entity other than that s ocluding details of your res	hown in Question		☐ Yes ☐ No hold-harmless
	l. A	Are you employ	ed by or under contract	to any governmental entit acluding details of your res	-		☐ Yes ☐ No
	m. Is		•	r the Health Insurance Poi	•	untability Act of 1996	(HIPAA)
	I1			rocedures to comply with ant's Privacy Officer			☐ Yes ☐ No ☐ Yes ☐ No
	n. P	Provide the follo	owing information for all	of the states in which you	ı practice:		
		<u>State</u>	<u>License No.</u>	Effective Date	Expiration	n Date	Active (Yes/No)
	p. P	Are you licensed If no, please a Please describe	ttach an explanation.	licable state and federal r		ls, seminars, etc., on a	☐ Yes ☐ No ttached
2		CATION:		uu (e).			
۷.	a.		professional training:				
	ŭ.	-	ame & Address)	<u>Years</u>	s of Training	Degree or Cer	tification Attained
				From	To		
				From	То		
3.	FXF	PERIENCE:					
٠.			racticed your profession	during the last ten years:			
	a.			To:		Location:	
	b.			To:		Location:	
		Practice Activi	ity:				
	c.	Prior Experien	ice - From:	To:		Location:	
	d.			licensing or specialty orga		tion?	☐ Yes ☐ No
		if yes, please a	attach a detailed explan	ation, including dates and	location.		
4. `	YOU	R PRACTICE:					
	a.	_		ges of time spent in the fo			
		% Admir % Ambu	nistrative Office	% Hospital W % Operating	vard (specify)	% Other (specify)	
		% Affibu % Classr		% Operating % Outpatien	t Clinic	% Other (specify) % Laboratory	
			ng Home/Assisted Living			% Laboratory % Surgery Cente	er
				ofession)			
			gency Dept of hospital	-			

Holistic Medicine	b.	Please indicate the a Hemodialysis		-	-		Onbthalmalagi			0/
Dental		•	%			%	-			% %
Stress Testing						/0	•	,		
Communicable										
Family Planning		_			tric				-	/0
A. Are you licensed to practice any other health care practices? Yes No No No RN RPT LAC MIDWIFE Other:			%		igement (
a. Are you licensed to practice any other health care practices? If Yes, please circle: MD DO DPM ND RN RPT LAC MIDWIFE Other: Please indicate those procedures or devices used in your practice:				-					-	100%
If Yes, please circle: MD DO DPM ND RN RPT LAC MIDWIFE Other: Description Do Description Do Description D	c. <u>Cł</u>	niropractors – please co	omplete the follo	owing:						
b. Please indicate those procedures or devices used in your practice: Yes No Yes No Yes No							E Other		☐ Yes 〔	⊒ No
(i) General merric adjusting (xvi) Messages (ii) Upper cervical specific (xvii) Short wave diathermy (iii) Instrumental adjusting (xviii) Khersiology (iv) Gonstead/diversified (xvi) Stressology (vi) Gonstead/diversified (xvi) Kiesiology (vi) Gonstead/diversified (xvi) Kiesiology (vi) Gonstead/diversified (xvii) Kiesiology (vi) Sacro-occipital (xviii) Kiesiology (vi) Sacro-occipital (xviii) Kiesiology (vi) Sacro-occipital (xviii) Kiesiology (vi) Sacro-occipital (xviii) Gemstone therapy (viii) Electrical stimulation (xviii) Gemstone therapy (xviii) Electrical stimulation (xvii) Tofness devise (xviii) Electrical stimulation (xviii) Tofness devise (xviii) Cold laser (xviii) Manipulation under anesthesia (xviii) Activator (xviii) Activator (xviii) Manipulation under anesthesia (xvii) Activator (xviii) Galvanic (xviii) Manipulation under anesthesia (xvii) Ultraviolet (xvi) Ultraviolet (xviii) Ultraviolet (xviii) Manipulation under anesthesia (xviii) Manipulation under anesthesia (xviii) Manipulation under anesthesia (xviii) Malvayis cenig a patient or when seeing a patient you have not seen for six months? Yes Nviii No, please describe how you assess vascular flow. (i) Make a differential diagnosis? Yes Nviii Malvayis record the patient's account of his/her progress? Yes Nviii Malvayis record the patient's account of his/her progress? Yes Nviii Malvayis record the patient's account of his/her progress? Yes Nviii Malvayis record the patient's account of his/her progress? Yes Nviii Malvayis record the patient's account of his/her progress? Yes Nviii Malvayis record the patient's account of his/her progress? Yes Nviiii Malvayis record the patient's account of his/her progress? Yes Nviiii Malvayis record the patient's account of his/her progress? Yes Nviiii Malvayis record the patient's account of his/her progress? Yes Nviiii Malvayis record objective findings? Yes Nviiii Malvayis record o		•					L Other.			
(ii) Upper cervical specific		b. Please illuicate	nose procedures		-	our practice.			<u>Yes</u>	<u>No</u>
(iii) Instrumental adjusting (xviii) Knesiology		(i) General m	erric adjusting			(XVI) Messages	5			
(iv) Gonstead/diversified		(ii) Upper cerv	ical specific			(xvii) Short wa	ave diathermy			
(vi) Direct non-force (xxi) Stressology (vi) Sacro-occipital (xii) Hydroculator/heat packs (xiii) Internal cocoyx adjustment			-							
(vii) Sacro-occipital (xxiii) Internal cocoyx adjustment (viii) Hydroculator/heat packs (xxiii) Gemstone therapy (viii) Electrical stimulation (xxiii) Cemstone therapy (viii) Electrical stimulation (xxiii) Toftness devise (xxii) Cold laser (xxiii) Cold laser (xxiii) Cold laser (xxiii) Cold laser (xxiii) Cavwiii) Manipulation under anesthesia (xxiii) Activator (xxiii) Calwanic (xxiv) Department of Company (xxiv) Ultrasound (xiv)										
Viii Hydroculator/heat packs		(v) Direct non	-force							
Viii) Electrical stimulation						, ,		t		
(ix) Ice-cryotherapy (xxvi) Treat cancer (xxvi) Treat cancer (xxvi) Treat epilepsy (xvii) Cold laser (xxviii) Manipulation under anesthesia (xviii) Cald laser (xxviii) Manipulation under anesthesia (xviii) Cald laser (xxvii) Manipulation under anesthesia (xvii) Activator (xxvi) Prenatal care & normal deliveries (xvii) Ultraviolet (xv) Ultrasound (xv) Ultrasound (xv) Ultraso										
(x) Trigger point (xxvi) Treat epilepsy (xxviii) Manipulation under anesthesia (xii) Activator (xxviii) Galvanic (xxv) Ultravolet (xxv) Ultravolet (xxv) Ultravolet (xxv) Ultrasound (xxv) Prenatal care & normal deliveries (xxv) Prenatal care & normal deliveries (xxv) Ultrasound (xxv) Prenatal care & normal deliveries (xxv) Prenatal care & normal deliveries (xxv) Ultrasound (xxv) Ultrasound (xxv) Prenatal care & normal deliveries (xxv) Ultrasound (xxv) Ultrasoun		• •				, ,				
(xi) Cold laser (xii) Activator (xiii) Galvanic (xiii) Galvanic (xiv) Ultravoidet (xv) Ultrasound d. 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? If No, please describe how you assess vascular flow. If an unusual finding results, do you refer the patient to the appropriate medical practitioner? (ii) Make a differential diagnosis? (iii) Always record the patient's account of his/her progress? (iv) Always record details of treatment procedures? (v) Always record details of treatment procedures? (v) Always record details of treatment procedures? (v) Always record details of treatment procedures? (iii) Attach a Certificate of Insurance evidencing that you have Professional Liability Insurance for your full-time practice. Do you work for and/or accept work assignments or placements from any locum tenens company? Yes On the practice of the patient's account of this you have Professional Liability Insurance for your full-time practice. Do you work for and/or accept work assignments or placements from any locum tenens company? Yes On the provided the following for each company: Employee or No. of Hrs. Is Prof. Liab. Insurance Name of Company Address Independent Contractor Each Month Provided to You? (Yes/No.) * If Yes, attach a copy of your Certificate of Insurance. If No, are you requesting coverage for this activity?						, ,				
(xiii) Activator (xiii) Galvanic (xiv) Ultravolet (xv) Ultrasound d. 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? If No, please describe how you assess vascular flow. If an unusual finding results, do you refer the patient to the appropriate medical practitioner? (ii) Make a differential diagnosis? (iii) Always record the patient's account of his/her progress? (iv) Always record details of treatment procedures? (v) Always record details of treatment procedures? e. The practice for which coverage is requested is: full-time part-time "moonlighting" fthe practice for which coverage is requested is part-time or "moonlighting" answer the following: (i) Provide the name and address of your full-time position and number of weekly hours not including on-call. (ii) Attach a Certificate of Insurance evidencing that you have Professional Liability Insurance for your full-time practice. Do you work for and/or accept work assignments or placements from any locum tenens company? Yes No. of Hrs. Is Prof. Liab. Insurance Yes No. of Hrs. Is Prof. Liab. Insurance Yes No. of Hrs. Is Prof. Liab. Insurance Name of Company Address Independent Contractor Each Month Provided to You? (Yes/No. of Hrs. Is Prof. Liab. Insurance Yes No. of Hrs. Ye			nt							
(xiii) Galvanic (xiv) Ultraviolet (xiv) Ultraviolet (xv) Ultrasound d. 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? If No, please describe how you assess vascular flow. If an unusual finding results, do you refer the patient to the appropriate medical practitioner? (ii) Make a differential diagnosis? (iii) Always record the patient's account of his/her progress? (iv) Always record objective findings? (v) Always record objective findings? (v) Always record details of treatment procedures? e. The practice for which coverage is requested is: part-time		` '								
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Employee or No. of Hrs. Is Prof. Liab. Insurance Name of Company Address Independent Contractor Each Month Provided to You? (Yes/No.) * If Yes, attach a copy of your Certificate of Insurance. If No, are you requesting coverage for this activity?	e.	(i) Use the Georges when initially se If No, please des If an unusual fin (ii) Make a differen (iii) Always record to (iv) Always record do (v) Always record do (v) Always record do (v) The practice for which is full-time If the practice for who (i) Provide the name (ii) Attach a Certific Do you work for and	s test, the Vertebeing a patient or scribe how you adding results, do you all diagnosis? The patient's accobjective findings etails of treatments coverage is really part-time and address of the and address of the accept work.	oral Artery In when seeing seess vasculou refer the unt of his/In? In procedure the unterprocedure is: In more than the unit of his/In it procedure is: In more than the unit of your full-the unit of his/In it procedure is: In the unit of his/I	Ischemia ng a patie ular flow. ne patient her progre ures? onlighting s part-time posit g that you ts or place	Test or the Cerebrokent you have not see to the appropriate ess? " e or "moonlighting" ion and number of what have Professional L	rascular Craniocers on for six months? medical practition answer the follow weekly hours not in	er? ving: ncluding on-c or your full-t	☐ Ye☐ Ye☐ Ye☐ Ye☐ Ye☐ Ye☐ Ye☐ Ye☐ Ye☐ II.	s O No
Name of Company Address Independent Contractor Each Month Provided to You? (Yes/No) * If Yes, attach a copy of your Certificate of Insurance. If No, are you requesting coverage for this activity?		If Yes, complete the	following for eac	h company		oloyee or	No. of Hrs.	<u>Is Prof. Lia</u>	<u>b. Insur</u> aı	<u>nce</u>
* If Yes, attach a copy of your Certificate of Insurance. If No, are you requesting coverage for this activity?		Name of Company	Δddr	229		<u> </u>				
If No, are you requesting coverage for this activity?		- Name of Company	Addi	<u> </u>	mac	pendent contracto	Lucii Wollin	1 TOVIACA (0 100: (1	<u> </u>
If No, are you requesting coverage for this activity?										
									☐ Ye	s 🖵 No
	ρ				-	iated with any locur	n tenens company	·?		

USRISK IND II 10.09 Page 3 of 6

h.	Are	you currently in active military service?		🖵 Yes 🖵 No
i.	Do	you render professional services directly to patients?		☐ Yes ☐ No
	If ye	es, please describe these services in detail and indicate	whether you are supervised and b	by whom.
	•	Detailed Description of Professional Services	Percent of time Supervised	Qualifications of Supervisor
			%	
			%	
			0/	
j.		you render professional services that do not involve cores, please describe these services in detail.		☐ Yes ☐ No
k.		you administer any anesthesia? es, please explain and indicate whether you are supervi	sed and by whom	☐ Yes ☐ No
l.	(i)	Do you perform or assist in any surgical procedure(s)? If yes, please answer (ii) below.		☐ Yes ☐ No
	(ii) (:::)	Please list ALL surgical procedures performed (including ls anesthesia (other than topical or by means of local in		
	(111)	yourself or others?	illilitation) administered by either	☐ Yes ☐ No
	(iv)	If yes, please attach a detailed explanation. Do you perform or assist in any surgical procedure(s) in	n a nrofessional office or similar	
	(10)	non-hospital facility?	in a professional office of similar	☐ Yes ☐ No
		If yes, please attach a detailed explanation.		
m.		, ,		☐ Yes ☐ No
		Psychiatric shock therapy?		☐ Yes ☐ No
n		you prescribe or dispense any drugs without the counte es, please provide a detailed explanation.	ersignature of a physician?	☐ Yes ☐ No
0.				
	(i)	Use acupuncture?		☐ Yes ☐ No
		If Yes, do you use the National Council on Certification clean needle technique?	of Acupuncturists (NCCA)	□ Yes □ No
		If No, do you use disposable needles?		☐ Yes ☐ No
		If No, please attach details.		
	(ii)	Dispense or prescribe: Drugs?		☐ Yes ☐ No
	(iii)	Use x-ray or imaging in treatment determination?		☐ Yes ☐ No
	(iv)	Engage in any procedure, other than acupuncture or the	e drawing of blood for diagnostic	purposes, requiring
		ne penetration of the skin?		☐ Yes ☐ No
		Perform investigational or experimental research or th		☐ Yes ☐ No
		ICANT HISTORY (ATTACH DETAILED EXPLANATION FOR A ve you:	ANY "YES" ANSWERS)	
a.		ve you. Ever been the subject of disciplinary or investigatory p	roceedings or renrimand by an	
	(1)	administrative or governmental agency, hospital or pro		☐ Yes ☐ No
	(ii)	Ever been convicted for an act committed in violation		
		traffic offenses?		☐ Yes ☐ No
		Ever been treated for alcoholism or drug addiction?	roccuibo on dianones regestias refer	☐ Yes ☐ No
	(IV)	Ever had any state professional license or license to pr renewal refused or accepted only on special terms or e		
	(v)	Ever had any insurance company or Lloyd's cancel, dec malpractice insurance?		
6.	Do	you currently carry the following insurance:		

	Policy From: MM/DD/YY	7	Го:	Insura	nce Company	Limit Liabili	Deduct	ble	Policy Form: Claims Made or Occurrence?	Premium
	/ /	/	/							
	/ /	/	/							
	/ /	/	/							
	/ /	/	/							
	/ /	/	/							
	If claims made	e, wha	t is the re	troactive	e date/prior acts	date on y	our current polic	y?		
b. C	ommercial Ge		_		bility Insurance c	-	arried by the firm		olicy Form: Claims	☐ Yes ☐ No
	Policy Perio	od	Carı	rier	Limit of Lial BI/PD	bility	Deductible		Made or Occurrence?	Premium
	If claims made	e, wha	t is the re	troactive	- data/nuiau aata					
					e date/prior acts	date on y	our current polic	λ;		
	IMS HISTORY:									
a. D	uring the past	five (5) years, h	ave there	e been any profe	ssional or	general liability o		or incidents made ag	ainst you, any
a. D	uring the past	five (5 mer em) years, h nployee, th	ave there	e been any profe nt or anyone propo	ssional or posed for thi	general liability c s insurance?	laims	or incidents made ag	
a. D	uring the past	five (5 mer em) years, h nployee, th ACH CUR I	ave therene applica	e been any profe nt or anyone propo VALUED COMPAN	ssional or so cosed for thi	general liability on sinsurance? JNS FOR THE PROPERTY OF THE	laims I OR FI	or incidents made ag VE (5) YEARS	ainst you, any
a. Di	uring the past	five (5 mer em) years, h nployee, th ACH CUR IF NO	ave therene applica RENTLY N PRIOR CO	e been any profe nt or anyone propo ALUED COMPAN OVERAGE, COMP	ssional or so posed for thi NY LOSS RU PLETE ATTA	general liability of sinsurance? JNS FOR THE PROPERTY SU	laims OR FI	or incidents made ag VE (5) YEARS MENT	ainst you, any □ Yes □ No
a. Di	uring the past mployee or form Are you, or an occurrence(s)	five (5 mer em ATTA nyone) years, h nployee, th ACH CUR IF NO proposed nay result	ave therene applica RENTLY V PRIOR CO	e been any profe nt or anyone propo ALUED COMPAN OVERAGE, COMP	ssional or posed for thing the second	general liability of sinsurance? JNS FOR THE PRACHED CLAIM SU	laims OR FI	or incidents made ag VE (5) YEARS	ainst you, any □ Yes □ No
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a. Die e b.	Are you, or an occurrence(s) If yes, provide ave there beer molestation?	five (5 mer em ATTA nyone that m to full do n any) years, haployee, the second of the second	ave there applicant applic	e been any profesont or anyone proportions of the proportion of the proportion of the profession of th	essional or so cosed for thing a second cosed for thing a second cosed for the second a secon	general liability of sinsurance? JNS FOR THE PROCEED CLAIM SUCTION (s), incident(s), and alleged of sout of alleged of sinsurance.	laims POR FI PPLEI ct(s), r actu	or incidents made ag VE (5) YEARS MENT event(s), circumstanc	ainst you, any Yes No ee(s) or Yes No
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*Notice applicable in most 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 conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

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ements and particulars are true and	I/we agree that this application shall be the basis of the
/	
Title	Date