U.S. Risk, LLC | 14241 Dallas Parkway, Suite 850, Dallas, Texas 75254

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

Please email this completed application to the U.S. Risk underwriter you are working with.
For contact information, please visit the U.S. Risk HealthcarePros webpage.

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

   Address: _____
   City: _____ State: _____ County: _____ ZIP: _____
   Contact Name: _____ Title: _____
   Contact Email Address: _____ Phone: _____
   Website URL: _____
   List all other locations:

2. Professional degree: _____
3. Place of birth: _____
4. Applicant is (check all that apply):
   - ☐ U.S. citizen (if not, provide status)
   - ☐ Self-employed individual (unincorporated)
   - ☐ Self-employed individual (incorporated)
   - ☐ Partnership
   - ☐ Professional association
   - ☐ Professional corporation (for profit)
   - ☐ Professional corporation (non-profit)
   - ☐ Employee of (give name of employer): _____
   - ☐ Other (describe): _____

5. Please indicate your professional specialty:
   - ☐ Chiropractor
   - ☐ Counselor
   - ☐ Dietician
   - ☐ Physician Assistant
   - ☐ Nurse Practitioner
   - ☐ Registered Nurse
   - ☐ Therapist
   - ☐ Veterinarian
   - ☐ Other (specify): _____

6. Date established: _____
7. Please state sources and amounts of total gross annual revenue:

Source of revenue	Amount last 12 months	Amount next 12 months
	$	$
	$	$
	$	$

8. If you practice **other than** as an **employee *or*** an **unincorporated solo practitioner**, specify:
   a. Formal business, corporate or partnership name: _____
   b. List the names of all partners or members of your professional association/corporation who provide professional services:

Attach a copy of your letterhead.

9. Are you associated with or do you work for a physician or surgeon? ☐ Yes ☐ No
   If yes, please give the name and specialty of the physician: _____
10. Are you employed by an individual other than that shown in question 1 above? ☐ Yes ☐ No
    If yes, please attach an explanation, including details of your responsibilities.
11. Are you under contract to any individual or entity other than that shown in question 1 above? ☐ Yes ☐ No
    If yes, please attach an explanation, including details of your responsibilities. If this contract contains a hold-harmless agreement, please attach a copy of the contract.
12. Are you employed by or under contract to any governmental entity? ☐ Yes ☐ No
    If yes, please attach an explanation, including details of your responsibilities.
13. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No
    If yes,
    a. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No
    b. Name and title of the applicant's privacy officer: _____
14. Provide the following information for all of the states in which you practice:

State	License Number	Effective Date	Expiration Date	Active?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

    If none, please attach an explanation.
15. Are you licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
    If no, please attach an explanation.
16. Describe professional training including formal classroom education, tutorials, seminars, etc., on attached sheet, or attach a current curriculum vitae (CV).

EDUCATION

Describe your professional training:

Institution Name and Address	Years of Training		Degree or Certification Attained
	From:	To:	
	From:	To:	
	From:	To:	
	From:	To:	

EXPERIENCE

Where have you practiced your profession during the last ten years?

1. From: _____ To: _____ Location: _____
   Practice activity: _____
2. From: _____ To: _____ Location: _____
   Practice activity: _____
3. From: _____ To: _____ Location: _____
   Practice activity: _____

4. Have you ever failed any professional licensing or specialty organization examination? ☐ Yes ☐ No
   If yes, please attach a detailed explanation, including dates and location.

YOUR PRACTICE

1. Approximate percentages of time spent in the following work locations **(must total 100%):**

_____ % Administrative office	_____ % Operating room	_____ % Laboratory
_____ % Ambulance	_____ % Outpatient clinic	_____ % Nursing home/assisted living
_____ % Classroom	_____ % Surgery center	_____ % Patient's home

   _____ % Hospital ward (specify): _____
   _____ % Professional office (specify profession): _____
   _____ % Emergency department of hospital (specify): _____
   _____ % Other (specify): _____

2. Please indicate the approximate division of your patients or clients among the following **(must total 100%):**

_____ % Hemodialysis	_____ % Bariatrics	_____ % Ophthalmologic
_____ % Holistic medicine	_____ % Obstetrical	_____ % Cosmetic surgery
_____ % Dental	_____ % Podiatric	_____ % Disability evaluation
_____ % Stress testing	_____ % Pediatric	_____ % Communicable

   _____ % Family planning
   _____ % Research or experimental (describe): _____
   _____ % Pain management (describe): _____
   _____ % Surgical (describe): _____

3. Are you a **chiropractor?** ☐ Yes ☐ No
   If yes, complete the following:
   a. Are you licensed to practice any other healthcare practices? ☐ Yes ☐ No
      If yes, please check as appropriate: ☐ MD ☐ DO ☐ DPM ☐ ND ☐ RN ☐ RPT ☐ LAC ☐ Midwife
      ☐ Other: _____
   b. Please identify the procedures or devices used in your practice:

i.	☐ General Meric adjusting	xv.	☐ Ultrasound
ii.	☐ Upper cervical specific	xvi.	☐ Messages
iii.	☐ Instrumental adjusting	xvii.	☐ Shortwave diathermy
iv.	☐ Gonstead/diversified	xviii.	☐ Kinesiology
v.	☐ Direct non-force	xx.	☐ Whirlpool
vi.	☐ Sacro-occipital	xxi.	☐ Stressology
vii.	☐ Hydroculator/heat packs	xxii.	☐ Internal coccyx adjustment
viii.	☐ Electrical stimulation	xxiii.	☐ Gemstone therapy
ix.	☐ Ice-cryotherapy	xxiv.	☐ Toftness device
x.	☐ Trigger point	xxv.	☐ Treat cancer
xi.	☐ Cold laser	xxvi.	☐ Treat epilepsy
xii.	☐ Activator	xxviii.	☐ Manipulation under anesthesia
xiii.	☐ Galvanic	xxx.	☐ Prenatal care and normal deliveries
xiv.	☐ Ultraviolet		

4. **If the answer to any of the following questions 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? ☐ Yes ☐ No

If no, describe how you assess vascular flow:

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

5. The practice for which coverage is requested is: ☐ Full-time ☐ Part-time ☐ "Moonlighting"

   If the practice for which coverage is requested is part-time or "moonlighting," complete the following:

   a. Name and address of your full-time position and number of weekly hours not including on-call:

   b. Attach a Certificate of Insurance evidencing that you have professional liability insurance for your full-time practice.

6. Do you work for and/or accept work assignments or placements from any *locum tenens* company? ☐ Yes ☐ No

   If yes, complete the following for each company:

Name of Company	Address	Employee or Independent Contractor?	Number of Hours Each Month	Is Professional Liability Provided to You?*
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

   ***If yes,** attach a copy of your Certificate of Insurance.

   If no, are you requesting coverage for this activity? ☐ Yes ☐ No

7. Are you a freelance locum tenens not placed by or associated with any *locum tenens* company? ☐ Yes ☐ No

8. Are you currently in active military service? ☐ Yes ☐ No

9. Do you render professional services directly to patients? ☐ Yes ☐ No

   If yes, describe these services in detail and indicate whether you are supervised and by whom:

Detailed Description of Professional Services	Percent of Time Supervised	Qualifications of Supervisor
	%	
	%	
	%	

10. Do you render professional services that do not involve contact with a patient? ☐ Yes ☐ No

    If yes, describe these services in detail:

11. Do you administer any anesthesia? ☐ Yes ☐ No

    If yes, explain and indicate whether you are supervised and by whom:

12. a. Do you perform or assist in any surgical procedure(s)? ☐ Yes ☐ No
    If yes, list ***all*** surgical procedures performed (including minor surgery):

    b. Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ☐ Yes ☐ No
    If yes, attach a detailed explanation.
    c. Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? ☐ Yes ☐ No
    If yes, attach a detailed explanation.
13. a. Do you perform radiation therapy? ☐ Yes ☐ No
    b. Psychiatric shock therapy? ☐ Yes ☐ No
14. Do you prescribe or dispense any drugs without the countersignature of a physician? ☐ Yes ☐ No
    If yes, provide a detailed explanation.
15. Do you:
    a. Use acupuncture? ☐ Yes ☐ No
    If yes, do you use the National Council on Certification of Acupuncturists (NCCA) clean-needle technique? ☐ Yes ☐ No
    If no, do you use disposable needles? ☐ Yes ☐ No
    If no, please attach details.
    b. Dispense or prescribe drugs? ☐ 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 investigational or experimental research or therapy on human patients? ☐ Yes ☐ No

APPLICANT HISTORY

1. Have you:
    a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ☐ Yes ☐ No
    b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
    c. Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
    d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ☐ Yes ☐ No
    e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

EXISTING INSURANCE

Do you currently carry the following:

1. Professional Liability Insurance? ☐ Yes ☐ No

   If yes, list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

   If claims made, what is the retroactive date/prior acts date on your current policy? _____

2. Commercial General Liability Insurance? ☐ Yes ☐ No

   If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

   If claims made, what is the retroactive date/prior acts date on your current policy? _____

CLAIMS HISTORY

1. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

   ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.
   IF NO PRIOR COVERAGE, COMPLETE CLAIM SUPPLEMENT.

2. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No

   If yes, provide full details:

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
   ☐ Yes ☐ No

   If yes, fully describe the circumstances and follow-up action taken:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING 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 FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

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.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____