

**Malpractice Insurance Application**



**Your Personal Information**

Last Name  First Name  Middle   
 Office Phone Number  Home Phone Number  Fax   
 Social Security Number  Date of Birth  Email   
 Practice Name   
 Primary Practice Address  City   
 State  Zip Code  County   
 Mailing Address (if different from Primary Practice Address)  City  State  Zip Code   
 Do you practice in more than one location?  Yes  No *If yes, please list other locations. If more space is needed, list on a separate*  
 Additional Practice Address  City   
 State  Zip Code  County  % of Patient Count   
 Chiropractic License Number(s)  State(s)  Date(s) First Licensed   
 State(s)  Date(s) First Licensed   
 Chiropractic College  Graduation Date   
 Have you ever previously applied to or been insured with OUM, PICA, or PACO?  Yes  No

**Your Practice**

1. You Practice: (select one)  
 a.  As an independent contractor with other doctors  
 b.  As an employee  
 Employer name   
 c.  As a sole practitioner-unincorporated  
 d.  As a sole practitioner-incorporated  
 e.  In a professional corporation in which you have ownership  
***If you selected d or e, please complete the following:***  
 Legal entity name   
 Tax ID number   
 Add this entity to my policy  Yes  No  
***If yes,***  Shared Limits  Separate Limits (additional cost)  
 The following information on each owner:  

Name	Health Care Specialty	Insurance Co.	Limits of Liability
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

 2. Total number of employees and independent contractor health care providers in your office (for example, CAs, massage therapists, X-ray technicians, etc.)   
 3. Average number of patients you see per week   
 4. Average number of hours you work each week

**Your Claims History**

1. Have you ever had a claim against you?  Yes  No  
***If yes, for each claim please provide:***  
 a. Copy of the Summons & Complaint (if applicable).  
 b. A brief narrative.  
 c. Current status of case, whether opened or closed. If open, list reserve amount. If closed, list settlement amount.  
 2. Are you aware of an incident that may result in a claim against you?  Yes  No  
***If yes, for each incident please give a narrative of the situation on a separate sheet.***  
 3. Have you ever:  
 a. had malpractice insurance declined, non-renewed for underwriting reasons, canceled or issued on a restricted basis?  Yes  No  
 b. had your chiropractic license subject to probation, revoked or suspended, or had a complaint filed against you?  Yes  No  
 c. been convicted of or pleaded no contest to a violation of any law or ordinance other than minor traffic offenses?  Yes  No  
 d. had any chronic illness, disability, or drug-or alcohol-related condition that affected your ability to practice chiropractic?  Yes  No



California Professional Insurance Services  
 14742 Plaza Drive, Suite 201  
 Tustin, CA 92780  
 Phone: 800-633-8884 Fax: 714-669-9230  
 Agency license #0773823



*Application Supplement*

1. Please list your home address: \_\_\_\_\_

2. Please indicate the number of the following in your practice:

	<u>Employees</u>	<u>Independent Contractors</u>		<u>Employees</u>	<u>Independent Contractors</u>
Chiropractors	_____	_____	Physicians	_____	_____
Chiropractic Assistants	_____	_____	Physical Therapists	_____	_____
Massage Therapists	_____	_____	Other	_____	_____
Acupuncturists	_____	_____			

For each employee and independent contractor listed above, please provide the following.:

<u>Name</u>	<u>Specialty</u>	<u>Malpractice Carrier</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Do you advertise your services?  Yes  No  
 If Yes, please include copies of your advertisements with this application.

4. Does your diagnostic protocol include obtaining a complete history including?  
 a. History of chief complaint?  Yes  No  
 b. Family history?  Yes  No

5. Do you perform acupuncture?  Yes  No License Number: \_\_\_\_\_

6. Do you perform Manipulation Under Anesthesia (MUA)?  Yes  No  
 If yes, please provide course certification and proctorship certification.

7. Do you include any of the following in your practice of chiropractic?  
 a. Hydraulic irrigation or mechanical expansion of the sinuses?  Yes  No  
 b. Colonic irrigation (hydraulic or pressure enema)?  Yes  No  
 c. Use of crystals to treat or diagnose?  Yes  No  
 d. Use of iridology to diagnose?  Yes  No

8. Do you own, lease or rent office space?  Yes  No  
 If yes, please complete the following:

Address (Street, City, Zip)	Hours per Week at this location
_____	_____
_____	_____
_____	_____

9. For each claim filed against you, please complete a claims information form (attached). You may make copies of the form as needed.
10. Please list any managed care providers to whom you would like us to send certificates:

<u>Provider Name</u>	<u>Address</u>	<u>Fax Number</u>	<u>Method</u>
			<input type="checkbox"/> Fax <input type="checkbox"/> Mail
			<input type="checkbox"/> Fax <input type="checkbox"/> Mail
			<input type="checkbox"/> Fax <input type="checkbox"/> Mail
			<input type="checkbox"/> Fax <input type="checkbox"/> Mail

For your protection, California law requires the following to appear on this form:  
 Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I understand that information submitted herein becomes part of the Applicant's Professional Liability Application.

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_  
 Date

Coverage provided by:  
 OUM Chiropractor Program, underwritten by PACO Assurance Company, Inc.  
 110 Westwood Place, Brentwood, TN 37027

**Claims Information**

**PLEASE MAKE COPIES OF THIS PAGE AS NEEDED**

Note: Please provide sufficient information for underwriters to evaluate the aspects of the case, especially relating to your involvement.

- 1. Name of Patient \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female
- 2. Allegation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 3. Date claim filed \_\_\_\_\_ Date of incident \_\_\_\_\_  
Location of occurrence \_\_\_\_\_
- 4. Insurance company providing coverage \_\_\_\_\_
- 5. Additional defendants \_\_\_\_\_
- 6. Disposition of claim  
 Open  
 Closed      Date closed \_\_\_\_\_ Total settlement or judgment \_\_\_\_\_  
Amount paid on your behalf \_\_\_\_\_

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of the claimant's office and hospital records, laboratory reports and any other information that would be appropriate. Attach additional sheets as required.

- 7. Condition and diagnosis at time of incident (Include dates of visit)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 8. Dates and description of treatment rendered (Include dates of visits)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 9. Condition of patient subsequent to treatment (Include dates of follow-up treatment)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that information submitted herein becomes part of the OUM Malpractice Insurance Application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date