

# Application for Membership



► Please complete the following:

First Name		Middle Name		Last Name	
Clinic Name					
Mailing Address			Office Address		
City	State	Zip	City	State	Zip
Office Telephone		Fax		Home Telephone	

Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex  M  F E-mail Address \_\_\_\_\_  
 License Number(s) \_\_\_\_\_ State(s) Issued \_\_\_\_\_ Date(s) First Issued \_\_\_\_\_  
 Chiropractic College or University \_\_\_\_\_ City, State, Country \_\_\_\_\_ Year of Graduation \_\_\_\_\_

► Please go on to pages 2 through 4 and then complete the payment information below:

**Scott Danahy Naylor**  
Insurance Brokers

300 Spindrift Drive  
Amherst, NY 14221  
www.scottdanahynaylor.com  
716-633-3400 Phone  
716-633-7141 Fax

**Total Amount Remitted:** \_\_\_\_\_

**Credit Card Authorization** (Visa or MasterCard only)

Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_

You are hereby authorized to charge the above referenced card for the amount indicated (to the left) as required to activate my coverage through the National Chiropractic Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature \_\_\_\_\_

# National Chiropractic Council Application

► Please complete the following:

1. Has any suit, arbitration, or other claim or proceeding been brought against you, your chiropractic partnership, your chiropractic corporation, associates, or employees for alleged malpractice?  
 YES  NO If YES, please give full details on a separate sheet
2. Do you know of any circumstances that would give rise to a claim being brought against you, your chiropractic partnership, your chiropractic corporation, associates, or employees for professional malpractice?  
 YES  NO If YES, please explain on a separate sheet
3. Has any government agency investigated, suspended, revoked, or taken any other action against your license to practice?  
 YES  NO If YES, please explain on a separate sheet
4. Have you ever had professional liability insurance refused, declined, canceled, or accepted on special terms?  
 YES  NO If YES, please explain on a separate sheet
5. Have you ever used any intoxicant, narcotic, or other psychoactive drugs to the extent that it has interfered with your ability to perform professional duties or have you ever been treated for drug or alcohol abuse or have you used any illegal drug in the past year?  
 YES  NO If YES, please explain on a separate sheet
6. Have you ever been convicted for an act committed in violation of any law or ordinance other than a minor traffic offense?  
 YES  NO If YES, please explain on a separate sheet
7. Has any professional association suspended, revoked, or taken any other adverse action against you or your membership in any such association?  
 YES  NO If YES, please explain on a separate sheet
8. Do you ever use stressology, internal coccyx adjustment, magnetic therapy, gemstone therapy, or the Toftness device?  
 YES  NO If YES, please explain on a separate sheet
9. Do you perform colonic irrigations or practice obstetrics?  
 YES  NO If YES, please explain on a separate sheet
10. Do you treat cancer or epilepsy?  
 YES  NO If YES, please explain on a separate sheet
11. Do you ever perform, or intend to perform in the next year, manipulation under anesthesia MUA?  
 YES  NO (To activate MUA coverage, a separate addendum must be approved.)
12. Do you ever charge or collect your fees per case, lump sum agreed on or paid in advance, or on contract with a patient for a pre-agreed sum?  
 YES  NO, I charge and collect only after services are rendered If YES, please explain on a separate sheet
13. Have you (or has a collection agency on your behalf) ever filed suit to collect unpaid sums from patients?  
 YES  NO If YES, please explain on a separate sheet
14. Do you ever use a collection agency to collect unpaid sums from patients?  
 YES  NO If YES, is your collection agency authorized to file suit?  YES  NO
15. Have you ever treated a person that had previously been a research subject in any research program in which you were involved?  
 YES  NO If YES, please explain on a separate sheet
16. Have you ever used a practice management company?  
 YES  NO If YES, give the name of the company: \_\_\_\_\_
17. Does anyone other than the following x-ray your patient: yourself, another D.C., qualified roentgenologist or radiologist, x-ray consultant, or licensed x-ray technician with formal training?  
 YES  NO If YES, please explain: \_\_\_\_\_

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► Please complete the following:

18. Do you treat Medicaid or Medi-Cal patients?  
 YES  NO If YES, what percentage of your practice is devoted to seeing Medi-Cal or Medicaid patients? \_\_\_\_\_ %
19. Do you use any technique or therapy that is not taught in the chiropractic schools or colleges?  
 YES  NO If YES, please list: \_\_\_\_\_
20. Do you regularly use the Georges Test, the Vertebral Artery Ischemia Test, or the Cerebrovascular Cranio Cervical Function Test?  
 YES  NO If NO, please explain on a separate sheet
21. Do you make a differential diagnosis?  
 YES  NO If NO, do you limit your responsibility to the treating of symptoms?  YES  NO
22. Is your chiropractic license(s) current?  
 YES  NO
23. Do you always require your patients to sign an informed consent prior to treatment?  
 YES  NO If YES, attach a copy of the form you use.
24. Do you always record the patient's account of his or her progress?  
 YES  NO  NO, but I will do so now
25. Do you always record objective findings?  
 YES  NO  NO, but I will do so now
26. Do you always record details of treatment procedures?  
 YES  NO  NO, but I will do so now
27. If the quality of an x-ray film is marginal, do you always do (or order) a retake?  
 YES  NO
28. Check one box describing your practice and fill in applicable blanks. Use a separate sheet if necessary.  
 Sole Proprietorship  
 Chiropractic professional corporation. Do you want corporate coverage? (additional charges may apply)  YES  NO  
 Partner in a chiropractic partnership: (Name partners) \_\_\_\_\_  
 Employee, associate, or independent contractor with: (Name employers) \_\_\_\_\_
29. Do you (or does your chiropractic corporation or chiropractic partnership) employ any chiropractors or other health care practitioners?  
 YES  NO If YES, for each employee, list name and type of practice (e.g. DC, MD, DO, DPM, CA, RN, PT)  
\_\_\_\_\_
30. At any of the offices where you work, are there any other doctors or health care practitioners (including doctors of chiropractic, medical doctors, doctors of osteopathy, acupuncturists, podiatrists, nurses, anesthetists, or physical therapist) or any student or graduate preceptees? Answer yes, if you work in a clinic together or if you share office space, reception area, personnel, equipment, or letterhead.  
 YES  NO, I am a solo practitioner (working alone with no other health practitioners or preceptees in the office(s)).  
If YES, for every other doctor or health care practitioner or preceptee, print name and type of practice (CA, MD, DO, L.Ac., DPM, RN, PT):  
\_\_\_\_\_  
\_\_\_\_\_
31. Are you licensed to practice any other health care professions?  
 YES  NO If YES, please circle all that apply: MD DO DPM L.Ac. RN RPT Other: \_\_\_\_\_  
If YES, name of the malpractice insurance company for the other profession? \_\_\_\_\_ Policy expires \_\_\_\_\_
32. Do you have chiropractic professional liability insurance?  
 YES  NO  
If YES, name of the malpractice insurance company \_\_\_\_\_ Policy expires \_\_\_\_\_
33. What date would you like your insurance to be in effect (may not be before the date your application is received)? \_\_\_\_\_

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► **Please complete the following:**

34. Do you refer to other doctors?  
 YES  NO If YES, please circle all that apply: MD Ortho Neuro GP L.Ac. RN RPT Other: \_\_\_\_\_
35. Approximate number of patients you see weekly? \_\_\_\_\_
36. How many hours per week do you spend in direct professional work with patients? \_\_\_\_\_
37. What is the average time you spend professionally with each patient on a first visit? \_\_\_\_\_ Follow up visit? \_\_\_\_\_
38. Please list all honors, recognition, awards, or publications of a professional nature: \_\_\_\_\_
39. List all hospitals at which you have held staff privileges or completed a residency and if applicable describe the circumstances under which such privileges were suspended or terminated (attach addendum if necessary).  
 None  
Hospital name: \_\_\_\_\_ City: \_\_\_\_\_ Dates: \_\_\_\_\_ Comments: \_\_\_\_\_
40. Please list all current memberships in chiropractic related specialty boards, academies, or colleges and dates so certified:  
 None \_\_\_\_\_
41. List all chiropractic teaching appointments you have held (attach addendum if necessary):  None  
School name: \_\_\_\_\_ Address: \_\_\_\_\_ Dates: \_\_\_\_\_
42. State pre-chiropractic education. Use a separate sheet if necessary.  
College/University: \_\_\_\_\_ Address: \_\_\_\_\_  
Degree: \_\_\_\_\_ Major: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

► **Member Application for Coverage:** (Please sign in the four required places below)

Print name: \_\_\_\_\_  
Last First Middle Initial

**1. MEMBER DECLARATION:** I hereby apply for malpractice insurance. I declare that the statements made in my Risk Purchasing Group Membership Application are true and that I have not suppressed or misstated any facts. I agree that this declaration will serve as the basis for, and form a part of, my malpractice insurance Policy. I understand that untrue statements could void both my Policy and membership.

Sign here: \_\_\_\_\_ Date: \_\_\_\_\_

**2. CLAIMS-MADE ONLY:** (Does not apply if your Claims Reporting Basis is "Occurrences") I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the Insured during the policy period arising out of the rendering or failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the Insured or Insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force) unless the Insured purchased an Extended Coverage Policy within 30 days after termination.

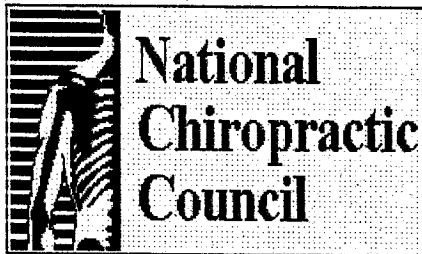
Sign here: \_\_\_\_\_ Date: \_\_\_\_\_

**3. RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS:** I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe professional practices may be based in part on information provided by me on future follow-up data sheets or during future pre-arranged office inspections. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

Sign here: \_\_\_\_\_ Date: \_\_\_\_\_

**4. RELEASE OF INFORMATION:** I hereby authorize release and exchange of information from: My professional associations, organizations, societies, any hospitals I presently or previously held staff privileges with, insurance carriers, trusts, administrators, etc., in past and future underwriting and claims matters, any State Licensing Board, and credit agencies to you or your authorized representative/investigator. I further agree that the organization releasing or obtaining the information, its agents, servants, and employees, shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I agree that a photocopy of this authorization will be as valid as the original.

Sign here: \_\_\_\_\_ Date: \_\_\_\_\_



**APPLICATION ADDENDUM  
REQUESTING ADJUSTED RATE FOR PART-TIME PRACTICE**

1. Name of Insured: \_\_\_\_\_

2. Please indicate the number of **Days / Week** worked at practice: \_\_\_\_\_

3. Please indicate the number of **Hours / Week** worked at practice: \_\_\_\_\_

4. Please provide your office hours for each day of the week:

Monday:	_____	hours
Tuesday:	_____	hours
Wednesday:	_____	hours
Thursday:	_____	hours
Friday:	_____	hours
Saturday:	_____	hours
Sunday:	_____	hours

4. Indicate the approximate number of patients you see weekly: \_\_\_\_\_

6. Please provide any additional information you feel would be useful to underwriting in validating your part time status:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Sign Here:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Based on the above information, underwriting will determine your eligibility for Part-Time Status in connection with your Professional Liability Coverage.