ChiroFutures RPG
Insurance Program

Administered by
Sonoran National Insurance Group
Phone: (800) 219-9090 Fax: (800) 219-9619
Email: chirofutures@sonorannational.com
*administrator licensure in certain States is through Peakstone Financial Services

Congratulations on taking your first step to becoming a ChiroFutures Member!

It's easy to apply for malpractice coverage through ChiroFutures. Just follow the simple steps outlined below:

- ➔ **Complete:** All questions on the application. This can be completed on line, then printed and mailed or you can print the application and complete by hand.
- ➔ **Include:** Where appropriate, provide detailed explanations of specific questions on a separate page and any necessary documents required. (board, claim info, etc)
- ➔ **Attach:** The required copies of your current policy declarations page if currently insured and your current chiropractic license.
- ➔ **Sign:** Where indicated at the bottom of page 5.
- ➔ **Save time:** In a hurry to get covered? Send along proof of coverage for any chiropractors, massage therapists or other licensed professionals that are in the same office and copies of your practice letterhead and all advertising.
- ➔ **Return:** You may return these items by one of the following methods. Use whatever method is most convenient for you:

FAX: 800-219-9619

MAIL: ChiroFutures RPG
Sonoran National Insurance Group,
7502 E Pinnacle Peak Rd, B210, Scottsdale, AZ 85255

EMAIL: chirofutures@sonorannational.com

Reminder: Unfortunately, incomplete applications or submissions missing critical underwriting documentation cannot be processed. Contact our office if you need assistance in compiling the necessary information. Our team is happy to help.

Please contact us at chirofutures@sonorannational.com or call (800) 219-9090 or (480) 538-7179. Thank You!

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☐ **Great Divide Insurance Company** ☐ **Nautilus Insurance Company** ☐ **Admiral Insurance Company**

CHIROPRACTIC PROFESSIONAL LIABILITY INSURANCE APPLICATION

Instructions:

- The application and any additional sheets must be completed, signed and dated by the applicant.
- Answer all questions completely. If the question does not pertain to your practice, answer "N/A".
- If additional space is needed, please use a separate sheet of paper.
- Type or print clearly in ink. DO NOT USE PENCIL.

I. PERSONAL INFORMATION

Name: _____ Date of Birth: __/__/___
(first) (middle) (last)

Practice Address: _____County:_____
(street) (city) (state) (zip)
Additional Practice Locations, if any. If "none" please indicate:_____
_____

Mailing Address: _____
(street) (city) (state) (zip)

Home Address: _____
(street) (city) (state) (zip)

Office Phone: (___)_____Home or Cell Phone: (___)_____Fax: (___)_____

Email:_____ Secondary Email: _____

Website: _____

LICENSE, EDUCATION AND QUALIFICATION INFORMATION

Chiropractic College Attended: _____ Date of graduation___/____/_____
(Institution) (City & State)
Additional Specialty Degrees or Certificates, if any (Please do not abbreviate):
_____

Original License Date: ___/___/_____ Date first started practicing as licensed Chiropractor: ____/_____/_____

Important: Please attach a copy of your current license

List all states in which you hold or have held a chiropractic license.

STATE	LICENSE NUMBER	PERIOD OF LICENSURE

List Chiropractic Association Memberships:_____

II. POLICY INFORMATION

1. Requested Effective Date of coverage (subject to underwriting approval) ____/____/_____

   Requested Policy Form: ☐ Occurrence ☐ Claims Made

   a) Do you desire Prior Acts Coverage? ☐ YES ☐ NO

   b) If so, what is the Retroactive/Prior Acts date on your current Claims Made Policy?___/___/___

You must attach a copy of your most recent Declarations Page to receive retroactive coverage (Subject to underwriting approval).

2. List all Current and Prior Malpractice Carriers and Policy Information for the past (5) years

INSURANCE COMPANY	POLICY PERIOD		LIMITS OF LIABILITY	POLICY TYPE	
	From	To		Claims-Made	Occurrence

If you do not have a current malpractice insurance policy or have not had coverage in the last 5 years, please provide an explanation of why you were uninsured.

_____

_____

3. Limits of Liability requested:

☐ $100,000 each Wrongful Act / $300,000 Aggregate
☐ $200,000 each Wrongful Act / $600,000 Aggregate
☐ $250,000 each Wrongful Act / $750,000 Aggregate
☐ $500,000 each Wrongful act / $1,500,000 Aggregate
☐ $1,000,000 each Wrongful Act / $3,000,000 Aggregate
☐ $2,000,000 each Wrongful Act / $4,000,000 Aggregate

III. CURRENT PRACTICE INFORMATION

1. If you work as an **employee or independent contractor**, please provide the name of the facility where you work and the name and professional licensure and/or designation of owner:_____

Are any additional insured's (i.e Landlord, Owner, etc.) needed for your practice?

If you are an employee, please proceed to question #3 of III.

2. If you own your practice, please advise of the following:

A) Business structure under which you practice: ☐ Sole Proprietor ☐ Incorporated, P.C. or P.A.

B) ☐ L.L.C. or L.L.P. ☐ Partnership ☐ Other (Please specify) _____

C) Please provide the name of your legal entity (if any):_____

FEIN or TAX ID number of the legal entity: _____

D) Including yourself, name shareholders, owners, officers, partners, etc, their professional designation and relationship:

Name	Professional Designation	Relationship

E) Do you desire a **shared** or **separate** limit of liability to apply to your legal entity?

☐ Shared (limits are shared with you at no cost)

☐ Separate (subject to approval. Entity has its own set of limits and additional charge applies)

3. Besides yourself, indicate the number of all chiropractors who work in your office or with whom you share space: _____ **Attach a separate application or proof of professional liability for each individual**.

4. Please complete the table below and advise the number of health care professionals working in practice:

Type	# Employed	# of Ind. Contractor	# Sharing Space
Chiropractor			
Chiropractic Assistant			
Massage Therapist			
Other (specify)			

IMPORTANT: Attach proof of professional liability insurance (other than your C.A.) for all employees, Independent Contractors and shared space arrangements.

5. How many total hours per week are you practicing (includes time spent treating patients, noting charts and consulting, i.e. IME, Utilization Review, and Peer Review)?_____

If 20 hours or less, complete a Part-Time Supplement

6. Are you a team physician for any professional sports organization? ☐ YES ☐ NO
   If yes, please indicate the name of the team(s)_____
7. Have you attended a risk-management seminar in the last 24 months? ☐ YES ☐ NO
   Presenter:_____ Subject: _____
8. Do you use an "Informed Consent" in your office? ☐ YES ☐ NO
9. Do you have practice advertisements? (i.e. pamphlet, newspaper: If yes include copy) ☐ YES ☐ NO
10. If you are a provider for any Managed Healthcare Organizations, HMOs, PPOs, etc., please list them all. Check the adjacent box if you wish to add them as a Certificate Holder (C.H.)
    _____ ☐ Add as C.H.
    (Organization Name) Mailing Address- Required for C.H.)
    _____ ☐ Add as C.H.
    (Organization Name) Mailing Address- Required for C.H.)

IV. CLINICAL PRACTICE INFORMATION

1. Please indicate the average number of patients seen monthly:_____
2. Check each of the following items provided by you or someone employed by you in your practice . If you order tests, but the actual procedure is referred out, please identify by checking the "RO" box (Referred Out).

✓	Procedure	Refer
☐	Adjustments	RO ☐
☐	Cryotherapy	RO ☐
☐	Litmus Paper (B.E.S.T.)	RO ☐
☐	Ultra Sound	RO ☐
☐	Auriculotherapy	RO ☐
☐	MRI/CT Scan	RO ☐
☐	Diathermy	RO ☐
☐	Galvanic Stimulation	RO ☐
☐	Interferrential	RO ☐
☐	Microcurrent	RO ☐
☐	Traction	RO ☐
☐	Functional Neurology	RO ☐
☐	Spinal Decompression	RO ☐
☐	Brain Core Therapy	RO ☐
☐	Morphogenic Field Technique	RO ☐
☐	Other (describe)	RO ☐
	_____	

✓	Procedure	Refer
☐	Hair Analysis	RO ☐
☐	Treatment or Diagnosis of Disease other than N.M.S.	
☐	Foot Bath	RO ☐
☐	Interpretation of Diagnostic Blood Studies	RO ☐
☐	Urinalysis	RO ☐
☐	Homeopathy	RO ☐
☐	Acupuncture	RO ☐
☐	Colon Irrigation	RO ☐
☐	Drugs prescribed or injected	RO ☐
☐	Minor Surgery	RO ☐
☐	Gynecology Exams	RO ☐
☐	MUA (Manipulation under Anesthesia)	RO ☐
☐	Obstetrics	RO ☐
☐	Vitamin Injections	RO ☐
☐	Iridology	RO ☐
☐	Invasive EMG	RO ☐

3. Percentages of Patients:

Newborn (Birth to 12 weeks)	%
Pediatrics (12 weeks to 12 years)	%
Pregnant	%
Remainder	%

4. Do you use any method or procedure other than non-force, or low-force for Newborn, Pediatrics or Pregnant patients? [ ] YES [ ] NO If yes, you must explain on a separate page. Please include any special certifications held.
5. Percentage of annual income generated from Nutritional Supplements %

V. UNDERWRITING INFORMATION

1. If the answer to any of the following questions is "YES", please attach the information requested.
   a. Have you ever been convicted, found guilty, pleaded nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations or any criminal charges pending and unresolved in any state or jurisdiction other than a minor traffic violation? [ ] YES [ ] NO
   If yes, provide details from investigating agency.
   b. Have you ever been convicted of, pleaded guilty or no contest to a crime or a traffic violation involving drugs or alcohol? [ ] YES [ ] NO
   If yes, provide details from investigating agency.
   c. Have you ever suffered from or been treated for substance abuse, disability, mental illness, or serious physical illness/injury? [ ] YES [ ] NO
   If yes, provide letter from treating physician with complete details.
   d. Have you ever had a complaint filed against you (by a patient, other chiropractor, or insurer) or an investigation conducted or pending with any any chiropractic board, association, foundation, state or federal government authority including Licensing Board, Medicare, etc? [ ] YES [ ] NO
   If yes, provide a copy of the board documents including resolution.
   e. Have you ever had any professional license or permit investigated (even if dismissed), suspended, revoked, restricted or placed under probation? [ ] YES [ ] NO
   If yes, provide a copy of the board documents including resolution
   f. Have you ever received a letter of concern/warning from the Board of Chiropractic Examiners (of any state) or been under a board's probation or stipulation? [ ] YES [ ] NO
   If yes, provide a copy of the board documents including resolution.
   g. Have you ever entered into any voluntary stipulation, order, consent agreement, or similar action with a Board of Chiropractic Examiners (of any state)? [ ] YES [ ] NO
   If yes, provide a copy of the board documents including resolution.
   h. Have you ever been denied any professional license or certification by a specialty board? [ ] YES [ ] NO
   If yes, provide details from investigating agency.
2. Have you ever had professional liability insurance policy declined, canceled, issued on special terms or been non-renewed, including for reasons of non-payment? [ ] YES [ ] NO
   (This question is not applicable to Missouri residents.)
3. Have any claims or suits ever been made or brought against you? [ ] YES [ ] NO
   If yes, complete one Supplemental Claim Information form for each incident.
4. Have you become aware of any fact or circumstance which resulted in or which could reasonably be expected to result in a malpractice Claim, Incident or Suit? [ ] YES [ ] NO
   If yes, please complete one Supplemental Claim Information form for each incident.

Additional Comments/Notes :

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT: (1) IF THE POLICY IS ISSUED, THIS IS DONE IN RELIANCE UPON THESE REPRESENTATIONS; AND, (2) ANY POLICY OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION IS NULL & VOID.

I AGREE THAT A COPY OF MY SIGNATURE MAY BE RELIED UPON AS IF IT WERE THE ORIGINAL.

_____

Print or Type Name

_____

Signature Date of Signature

If you have any questions about any part of this application, please call 800-219-9090.

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PART TIME SUPPLEMENTAL QUESTIONNAIRE

(Part Time is defined as 20 hours or less per week.)

Name: _____ Effective Date: _____ Policy Number: _____

Address: _____ City, State, Zip: _____

1. The TOTAL hours per week that I spend treating, adjusting, and consulting; including patient paperwork, IME, Utilization Review and Peer Review are:_____

2. Practice Office Hours each week are::

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

3. Reason for Part-Time practice: ☐ Disabled ☐ Family commitments ☐ Semi-retired

☐ Other Reason, (Please specifically detail) _____

In consideration of a significant premium discount on my Professional Liability policy, I hereby attest that I render professional patient services, no more than 20 hours each week in my practice. This includes hours spent handling direct patient care, patient record keeping and all other activities related to chiropractic patient services. I intend to maintain this schedule for the duration of my twelve-month policy period.

_____

Signature of Insured Date of Signature

IMPORTANT: If during the policy term, I am regularly exceeding the hours stipulated here, I will notify ChiroFutures of the change immediately, in order to correct this representation. I understand this representation is subject to audit and verification. I agree to make available to the carrier my work schedule, office schedule and other documentation necessary to confirm part time status. Should an audit disclose that professional services were regularly rendered in excess of the representation above, I agree to promptly remit the necessary additional premium.

VI. CLAIM INFORMATION

Supplemental Claim Information

Please type or print clearly.

1. Name of patient_____
2. Age_____
3. Sex_____
4. Allegation(s) (as stated by patient/plaintiff):_____

   _____
5. A. Date of incident _____B. Date reported to Insurer:_____
6. Insurance Carrier:_____
7. Other Defendants:_____
8. Present Status : ☐ Incident Report Only

   ☐ Open Claim Suit Filed: ☐ YES ☐ NO

   ☐ Settlement, or ☐ Judgment

   ☐ Closed Claim Date closed:_____ Amount Paid:_____
9. Condition and diagnosis at time of incident:_____

   _____
10. Dates and description of treatment rendered:_____

    _____
11. Condition of patient subsequent to treatment:_____

    _____
12. Current condition of patient: _____

    _____

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

*Signature X*_____ *Date:* _____

Please attach the National Practitioner Data Bank Submission Form.

FRAUD NOTICE/WARNING:

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For you protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MINNESOTA APPLICANTS: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: 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 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 TO OHIO APPLICANTS: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO TENNESSEE & VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCECOMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.