SHAND MORAHAN & COMPANY, INC.
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

APPLICATION FOR ACUPUNCTURISTS PROFESSIONAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Name of Applicant (include professional degree if applicant is individual): _____

_____

b. Business Phone: ( ) _____ Home Phone: ( ) _____

c. Applicant's Date and Place of Birth or Date Established: _____

d. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

Attach list of any additional locations

e. Square feet of total office space (all locations): _____

f. Applicant is:

[ ] U.S. Citizen
[ ] 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) _____

_____

g. Is coverage desired for the Corp./PA/Partnership? [ ] Yes [ ] No

h. The business, corporate or partnership name is: _____

i. Please give names of all partners or members of the firm who provide professional services: _____

_____

j. Please attach a copy of letterhead or other business stationery.

k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? .....[ ] Yes [ ] No

If yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .....[ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer. _____

Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

2. PROFESSIONAL INFORMATION

a. Does your state license or register acupuncturists? [ ] Yes [ ] No. Applicant's license number _____

Expiration Date: Mo_____/Day_____/Yr_____

b. Are you NCCA certified? [ ] Yes [ ] No

If yes, please provide date of certification, certificate number, expiration date of certificate:

Date of Certification: Mo_____/Day_____/Yr_____ Certificate #_____

Expiration Date: Mo_____/Day_____/Yr_____

c. Are you a member of AAAOM? [ ] Yes [ ] No. Current Member No. _____

d. Please describe Professional training including formal classroom education, tutorials, seminars, etc., on attached sheet, or attach a current curriculum vitae (C.V.).

e. Please indicate your professional specialty:

[ ] Acupuncture & Oriental Medicine
[ ] Chiropractor
[ ] Counselor (Describe) _____
[ ] Dental Hygienist
[ ] Hearing Aid Fitter
[ ] Home Health Care Agency
[ ] Inhalation Therapist
[ ] Laboratory Technician
[ ] Medical Personnel Pool
[ ] Naprapath
[ ] Nurse, Licensed Practical
[ ] Nurse, Registered
[ ] Nurses Registry
[ ] Occupational Therapist
[ ] Optician
[ ] Orthotist
[ ] Perfusionist
[ ] Pharmacist
[ ] Physical Therapist
[ ] Psychologist
[ ] Social Worker
[ ] Speech Therapist
[ ] Veterinarian
[ ] Visiting Nurse Assoc.
[ ] X-ray Technician
[ ] Other (Specify) _____

f. Please indicate professional societies or association in which you are a member: _____

_____

3. OPERATIONS

a. Please indicate percentage of time spent in the following work locations:

____% Administrative Office
____% Nursing Home
____% Outpatient Clinic
____% Professional Office (specify profession) _____
____% Other (specify) _____
____% Classroom
____% Outpatient Clinic
____% Patient Home

b. State approximate division of your patients or clients among:

(a)	Holistic Medicine	(___%)	(h)	Physician Rehabilitation	(___%)
(b)	Psychiatric	(___%)	(i)	Disability Evaluation	(___%)
(c)	Drug Addicts	(___%)	(j)	Research or Experimental	(___%)
(d)	Alcoholics	(___%)	(k)	_____	(___%)
(e)	Obstetrical	(___%)	(l)	_____	(___%)
(f)	Dental	(___%)	(m)	_____	(___%)
(g)	Pediatric	(___%)	(n)	_____	(___%)

c. Please state sources and amounts of total annual revenue:

Source of Revenue	Amount Last 12 Months	Amount Next 12 Months
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. PERSONNEL

a. List the number of your employees and volunteers.
IF NONE, STATE NONE.

Number	Type of Employees/Volunteers
_____	_____
_____	_____
_____	_____

b. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ..... [ ] Yes [ ] No
If no, please attach explanation.

c. Do you supervise any individuals other than your own employees? ..... [ ] Yes [ ] No
If yes, provide detailed explanation of responsibilities and relationships to the entity which employs these individuals.
Also indicate by profession the number of individuals supervised.

Number	Type of Professional
_____	_____
_____	_____
_____	_____

d. Please provide number of patient or client encounters:

Type of Visit	Number of Visits Last 12 months	Number of Visits Next 12 Months
Clinic	_____	_____
Office	_____	_____
Other_____	_____	_____
Total Number of Visits	_____	_____

5. SERVICES

a. Do you render professional services directly to patients? ..... [ ] Yes [ ] No.
If yes, please described in detail these services and indicate extent of supervision by others.

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

b. Do you render professional services that do not involve contact with a patient? ..... [ ] Yes [ ] No
If yes, please describe in detail these services. _____

_____

c. Do you perform or assist in any surgical procedures? ..... [ ] Yes [ ] No

(i) Please list ALL surgical procedures performed (including minor surgery).

(ii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ..... [ ] Yes [ ] No
If yes, please attach detailed explanation.

(iii) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? ..... [ ] Yes [ ] No
If yes, please attach detailed explanation.

6. PROCEDURES

a. Do you prescribe or dispense any drugs without the countersignature of a physician? .....[ ] Yes [ ] No
If yes, please provide detailed explanation. _____

_____

_____

b. Do you compound in bulk, manufacture wholesale oriental/herbal medicine or other nutritional substances or controlled substances? .....[ ] Yes [ ] No
If yes, please provide details. _____

_____

_____

c. Do you adhere to NCCA clean needle techniques? .....[ ] Yes [ ] No
Have you passed NCCA clean needle training course? .....[ ] Yes [ ] No
If yes, date passed: Mo_____/Day_____/Yr_____

7. BUSINESS ASSOCIATIONS

a. Are you associated with or work for a physician or surgeon? .....[ ] Yes [ ] No
If yes, please give name and specialty of physician._____

_____

b. Do you own or operate any business other than that shown in Question 1(a) above? .....[ ] Yes [ ] No
If yes, please give details on a separate sheet.

c. Are you employed by an individual other than that shown in Question 1(a) above? .....[ ] Yes [ ] No
If yes, please attach explanation, including details of your responsibilities.

d. Are you under contract to any individual or entity other than that shown in Question 1(a) above? .....[ ] Yes [ ] No
If yes, please attach explanation, including details of your responsibilities.
If this contract contains a hold-harmless agreement, please attach copy of contract.

e. Are you in the employ of, or under contract to any governmental entity? .....[ ] Yes [ ] No
If yes, attach explanation, including details of your responsibilities.

f. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory? .....[ ] Yes [ ] No
If yes, please attach a copy of ALL of its advertisements.

g. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? .....[ ] Yes [ ] No
If yes, please attach detailed explanation and a copy of ALL of the advertisements.

h. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered? .....[ ] Yes [ ] No
If yes, please give details, including name, location, size and number of beds.

i. (i) Do you use a collection agency? .....[ ] Yes [ ] No
If yes, name of agency _____

(ii) Has the agency authority to file a collection suit at its discretion? .....[ ] Yes [ ] No

8. APPLICANT HISTORY

PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

a. Have you or any of your employees:

(i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or government agency, hospital or professional association? .....[ ] Yes [ ] No

(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? .....[ ] Yes [ ] No

(iii) Ever been treated for alcoholism or drug addiction? .....[ ] Yes [ ] No

(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refusal or accepted only on special terms or ever voluntarily surrendered same? .....[ ] Yes [ ] No

(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? .....[ ] Yes [ ] No

b. Has any claim or suit been brought against you and/or any of your employees? .....[ ] Yes [ ] No

If yes, a supplemental claim information form must be completed for each claim or suit.

c. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? .....[ ] Yes [ ] No

If yes, please give details on separate sheet.

d. List prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No
							[ ]	[ ]
							[ ]	[ ]
							[ ]	[ ]
							[ ]	[ ]

e. If prior professional liability insurance was on a claims made basis, advise the retroactive exclusion date of the coverage_____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.**

_____ _____

Name of Applicant Title (Officer, partner, etc.)

_____ _____

Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

MARKEL®
SHAND MORAHAN & COMPANY, INC.
Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

BROKER RISK SUMMARY

(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: