NCMIC
Insurance Company

What you need to know about NCMIC's Claims-Made Malpractice Insurance for Naturopathic Doctors

Claims-Made Coverage

Claims-Made policies provide coverage for incidents that occur and are reported in writing on or after the **retroactive date** of the policy, and before the policy expires, cancels or non-renews. Upon cancellation, you have the option to purchase an Extended Reporting Endorsement or "Tail Coverage," which will allow claims to be reported for an indefinite period of time after the policy is no longer active, as long as the injury occurred on or after the **retroactive date** and before the policy expired, non-renewed, or was cancelled. Note: The Extended Reporting Endorsement may not be available if your policy cancels for non-payment of premium.

The **Retroactive Date** defines the date coverage begins and after which claims may be reported once your policy is in effect. The **retroactive date** is stated on the declarations page and can be concurrent with the effective date of the policy, or a date other than the effective date of the policy upon which you and we agree coverage will be effective. However, if you purchased an extended reporting endorsement from your current carrier, your prior policy was an occurrence policy, or you have had a gap in coverage, the **retroactive date** will be concurrent with the effective date of the new Claims-Made policy.

Effective Date of Coverage

Upon approval of your application, your policy effective date may be no earlier than the day your completed application is received by NCMIC. If you choose to fax or email your application, the earliest effective date will be the day after it is received.

Professional Entity Coverage Options

- **Shared Limits:** This provides shared limits of liability coverage for the entity for no additional cost.
- **Separate Limits (Group Policy):** This provides separate limits of liability coverage for the entity as well as the insureds listed on the Schedule of Insureds. The premium for this coverage will be 20% of the total undiscounted base premium for each insured listed on the Schedule of Insureds. Important Note: In order to qualify for this coverage, all naturopathic employees, officers, directors, and partners must be insured with NCMIC on a group policy.

Application Checklist

- ✔ Include a copy of your most recent declarations page from your previous carrier.
- ✔ Include a copy of all active licenses you hold.
- ✔ If coming from a previous carrier, the effective date of the policy must be on or after the cancellation date of your previous policy.

Please completely fill out all areas on the application.

If any areas do not apply, please state, "N/A."

NCMIC Insurance Company

Request for Claims-Made Malpractice Insurance for Naturopathic Doctors

To help with timely approval of your request for coverage, please complete all questions and provide any additional requested documentation as indicated. If information provided isn't complete, coverage approval may be delayed or rejected. If your answer to any question is "NONE" or "NOT APPLICABLE," please write "N/A."

Application number: _____

Section A – GENERAL INFORMATION

1. Name: _____
   LAST FIRST MIDDLE INITIAL

2. Designation(s) (N.D., LAc, D.C., etc.): _____

3. Last four digits of your Social Security Number: _____

4. Date of Birth: _____ /_____ /_____ 5. Gender: ☐ Male ☐ Female

6. Name of Practice: _____
   This practice is a: ☐ DBA (doing business as) ☐ Legal Entity
   ✔ **If "legal entity," please complete the Request for Professional Entity Coverage Application.**

7. Practice Address: _____
   STREET CITY STATE COUNTY ZIP

8. Home Address: _____
   STREET CITY STATE ZIP

9. Mailing/Billing Address: _____
   STREET CITY STATE ZIP

10. Is your practice a home-based office? ..... ☐YES ☐NO
    ✔ **If "yes," please provide details on the attached Home-Based Office Form.**

11. Do you practice in more than one location? ..... ☐YES ☐NO
    ✔ **If "yes," please list additional locations on a separate sheet of paper.**

12. Office Phone: (_____) _____ Fax: (_____) _____ Home/Cell Phone: (_____) _____

13. Email Address: _____ Website Address: _____
    Your email address will never be sold. It will be used to send you important notices.

14. Name of institution where you received your naturopathic training: _____

15. Years attended: From _____ To _____

16. Graduation Date: _____ /_____ /_____ Original License Date: _____ /_____ /_____

17. Year you began practicing naturopathic medicine: _____

Section A – GENERAL INFORMATION (continued)

18. List all states where you currently practice, the license number, the license issuance date, the date of license expiration and the percentage of your practice in each state:

LICENSE NUMBER	STATE	ISSUANCE DATE	EXPIRATION DATE	% OF PRACTICE IN STATE

Total must equal 100% ☐

✔ **Please attach a copy of each active license you hold.**

Section B – COVERAGE INFORMATION

1. Are you currently insured? ..... ☐YES ☐NO

2. Please provide the following information regarding your professional liability insurance for the past five years:

INSURANCE COMPANY	DATES OF COVERAGE	CLAIMS-MADE OR OCCURRENCE	POLICY LIMITS	IF CLAIMS-MADE, WAS TAIL PURCHASED?
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO

✔ **Please provide a copy of your current/expiring Declarations Page showing your retroactive date, policy period and limits of liability.**

3. Desired Effective Date: _____ /_____ /_____
When your application is approved, your policy effective date can be on or after the day your completed application is received by NCMIC. If you choose to fax or email your application, the earliest effective date will be the day after it is received.

4. Are you requesting retroactive coverage from NCMIC? ..... ☐YES ☐NO
Retroactive Date: _____ /_____ /_____ (as evidenced on the current declarations page)

5. Desired Limits of Coverage ***(per incident/aggregate per policy year)***:

☐ $1 million/$3 million
☐ $500,000/$1 million
☐ $250,000/$750,000
☐ $200,000/$600,000
☐ $100,000/$300,000

The following are exceptions by state:

- Connecticut - ONLY limits available:
  - ☐ $1 million/$3 million
  - ☐ $500,000/$1.5 million
- Kansas - ONLY limits available:
  - ☐ $1 million/$3 million
  - ☐ $500,000/$1 million
  - ☐ $250,000/$750,000
  - ☐ $200,000/$600,000

Section C – PRACTICE INFORMATION

1. How would you classify your current practice?
   - ☐ Individual/Solo Practice with no legal entity
   - ☐ Owner of or Shareholder in a legal entity (LLC, PC, S-Corp, etc.)
   - ☐ Employee (Employer Name): _____
   - ☐ Independent Contractor (for whom): _____
   - ☐ Locum Tenens
   - ☐ Other: _____

   ✔ ***If you are the Owner or Shareholder in a legal entity, please complete the Request for Professional Entity Coverage form.***

2. Have you discontinued any procedures within the past 5 years?..... ☐YES ☐NO
   If "yes," please describe: _____

3. Do you have emergency protocols in place should a patient require hospitalization?..... ☐YES ☐NO
   If "no," please explain: _____

4. On average, are your office hours less than 20 per week including paperwork?..... ☐YES ☐NO
   a. Number of hours per week in direct professional work with patients: _____
   b. Total number of patients you see weekly: _____

Section D – PROFESSIONAL EXPERIENCE

1. Have you ever been convicted of, pleaded guilty to, or pleaded no contest to any violation of a law or ordinance other than a minor traffic offense? ..... ☐YES ☐NO
2. Have you been treated for alcoholism, mental illness or drug addiction?..... ☐YES ☐NO
   ✔ **If "yes," please attach a statement from your sponsor/treatment professional and provide your treatment completion date.**
3. Do you have any health problems (or any type of disability) which might affect your practice of naturopathic medicine? ..... ☐YES ☐NO
4. Have you ever been the subject of disciplinary proceedings or reprimanded by an administrative agency, hospital or professional association?..... ☐YES ☐NO
5. Have you ever been declined, canceled or refused issuance or renewal of malpractice insurance?..... ☐YES ☐NO
   ✔ **If "yes," please provide a copy of the notice.**
6. Has your professional/naturopathic license ever been suspended, restricted, revoked or voluntarily surrendered, or has probation ever been invoked? ..... ☐YES ☐NO

▶ **IF YOU ANSWERED "YES" TO ANY QUESTIONS IN SECTION D, please provide copies of applicable court or board documents.**

Section E – CLAIM INFORMATION

1. Have you had any malpractice claims in the past 5 years? ..... ☐YES ☐NO
2. Has any claim or suit for alleged sexual misconduct ever been brought against you?..... ☐YES ☐NO
3. Have you reported any incidents or claims to a previous insurance company which have not been resolved?..... ☐YES ☐NO
4. Are you aware of any claims or suits, or any conduct, circumstances, occurrences, or incidents likely to give rise to a claim that have not been reported to your prior insurer? ..... ☐YES ☐NO

▶ **IF YOU ANSWERED "YES" TO ANY QUESTIONS IN SECTION E, please complete the attached Past Claim/Incident Information Form.**

Section F – TREATMENT INFORMATION

1. Please list the percentage of your practice that consists of, or will consist of, the following treatment methods:

Basic Naturopathic Practice (Botanical Medicine, Homeopathy, Nutritional Counseling) ..... _____%

Acupuncture (please complete Section G) ..... _____%

Oral Chelation Therapy ..... _____%

Please list specific types of oral chelation therapy used and symptoms/indications for each type:

Experimental Procedures ..... _____%

Please list all details and, if FDA-approved program, please provide protocols: _____

_____

IV/IM Vitamin and Mineral Therapy ..... _____%

Please list symptoms/indications treated: _____

Do you mix your own solution? ..... ☐YES ☐NO

If "yes," please provide details: _____

Do you refer patients out who require Extravasation? ..... ☐YES ☐NO

Laser Treatment ..... _____%

Types of treatment: _____

Conditions treated: _____

Types of laser: _____

Minor Surgery ..... _____%

Defined as any in-office minor surgery including repair of superficial wounds, removal of foreign bodies, cysts and other superficial masses with local anesthesia as needed. Please indicate all minor surgical procedures performed in your office: _____

_____

Pain Management ..... _____%

Please list details: _____

Ultrasound ..... _____%

Types of conditions treated: _____

Weight Control ..... _____%

Do you prescribe a means of weight control other than diet or exercise? ..... ☐YES ☐NO

If "yes," please list: _____

_____

Other procedures not listed above: _____ _____%

Excluded Treatment Methods:

Cosmetic/Aesthetic Procedures, Obstetrics, Midwifery, Prenatal Care, Neonatal Care, Epidurals, Nerve Blocks, Sciatic Block Injections, Scar Injections, Cavernosal Injections, IV Chelation Therapy, Rectal Chelation Therapy, Needle Biopsy, NAET/BioSET/ Vega/EAV Testing, Schlerotherapy, Perineal/Episiotomy repair, Weight Loss Treatment Consisting of Mesotherapy, HCG, Phentermine, or Phendemetrazine, Prolotherapy Using Platelet Rich Plasma, Trigger Point Injections Utilizing Anything Other Than Homeopathic Solutions ..... _____%

Total (must equal 100%) _____%

Section G – ACUPUNCTURE AND ORIENTAL MEDICINE

If you would like your policy to include coverage for your licensed or certified Acupuncture and Oriental Medicine practice, please complete the following. **Additional coverage will not be provided if a question is left unanswered.** The charge for this endorsement is 15% of the base premium.

1. Do you want coverage for acupuncture services? ☐YES ☐NO
2. Are you licensed? ☐YES ☐NO
   ✔ **If "yes," please provide a copy of your license.**
3. Are you certified? ☐YES ☐NO
   ✔ **If "yes," please provide a copy of your certification.**
4. Are only disposable stainless steel needles used? ☐YES ☐NO
5. Are needles disposed of after each use? ☐YES ☐NO
6. Are impervious containers used for disposal of needles? ☐YES ☐NO
7. Are used needles and the disposal containers ultimately picked up by a waste hauler service that specifically handles hazardous waste? ☐YES ☐NO
   If "no," please explain: _____
8. Are needles removed from patient before 24 hours elapse? ☐YES ☐NO
   If "no," how long do needles remain in patient? _____

Section H – SIGNATURE REQUIRED

IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT. Acceptance of the premium does not constitute approval of the application.

I hereby acknowledge that the aforementioned statements and answers are correct and complete to the best of my knowledge and belief.

I understand that my Professional Liability coverage will be written on a Claims-Made form and acknowledge that this coverage will only respond to claims that are reported during the term of this policy. I also acknowledge that my Claims-Made coverage will not provide insurance coverage for claims that occurred prior to the Retroactive Date of my policy.

I understand that, should I decide to cancel this Claims-Made policy, and I desire to provide insurance protection for any claims that may have occurred during the term of the Claims-Made policy, but were not reported in writing to the insurance company before the date of the policy termination, I will be able to purchase tail coverage within sixty (60) days of the cancellation date.

For residents of all states except District of Columbia, Maine and Washington: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

District of Columbia residents: 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.

Maine and Washington residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

X _____ SIGNATURE X _____ DATE

X _____ AGENT SIGNATURE X _____ DATE

Mail to:
NCMIC Insurance Company
P.O. Box 9118
Des Moines, IA 50306

Fax to:
1-800-996-2642

Scan and email to:
submissions@ncmic.com

Questions? Call toll free
1-800-952-9935

The Naturopathic Malpractice Insurance Plan is offered through NCMIC's Diversified Health Risk Purchasing Group Association. Coverage is underwritten by NCMIC Insurance Company.

NCMIC
Insurance Company

Billing Information

This Billing Information form must be completed and signed prior to policy issuance and valid payment received before coverage is in force.

1. Applicant's Name _____
   LAST FIRST MIDDLE INITIAL

2. Choose your billing frequency: ☐ Annually ☐ Semi-Annually (not available in CT) ☐ Quarterly (not available in CT) ☐ Tri-Annually (CT only)

3. Select your payment method: ☐ Bank Account ☐ Credit/Debit Card

4. Would you like to have this premium payment and future premium payments automatically charged to this account on each premium due date? ***(You will receive reminder notices approximately 30 days in advance.)*** .....☐YES ☐NO
   • *If NO, the payment information below will be used for a one-time payment.*

Please complete the requested payment information below.

BANK ACCOUNT INFORMATION:

Bank Name: _____

ABA/Routing Number:_____ Account Number: _____

Name (as it appears on the account): _____

Accountholder Address: _____
STREET CITY STATE ZIP

CREDIT/DEBIT CARD INFORMATION:

Card Type: ☐ NCMIC MilesAway® Credit Card ☐ MasterCard® ☐ VISA® ☐ American Express® ☐ Discover®

Card Number: _____ Expires: _____ /_____
MO. YR.

Name (as it appears on card): _____

Billing Address: _____
STREET CITY STATE ZIP

Signature of Cardholder: X _____
(Required for all credit/debit card payments.)

PLEASE READ, SIGN AND DATE (for all payment methods)

For recurring payments through my bank account or credit/debit card:

BANK ACCOUNT: I hereby request and authorize NCMIC to draft my bank account to pay my premium. Drafts will occur on each premium due date via electronic debits, checks or drafts payable to the order of NCMIC. I agree that NCMIC's rights in respect to each draw shall be the same as if it were a check signed by me. This will remain in effect until I notify NCMIC to cease recurring payments. Should my bank account change, it is my responsibility to notify NCMIC.

CREDIT/DEBIT CARD: I hereby request and authorize NCMIC to charge my credit/debit card to pay my premium. Charges will occur on each premium due date. The authorization will remain in effect until I notify NCMIC to cease recurring payments. NCMIC will assume my credit/debit card renews on a two-year basis and submit charges accordingly (except MilesAway, which renews on a three-year basis). Should my credit/debit card change, it is my responsibility to notify NCMIC.

For one-time payment: I acknowledge that I am the accountholder or have authorization to use this bank account or credit/debit card for a one-time payment. I hereby request and authorize NCMIC to draft this bank account or charge the credit/debit card listed above for the current premium due. This authorization is only valid for the current premium due and does not apply to any future payments due.

Authorized Signature X _____ **Date X** _____

NCMIC
Insurance Company

Home-Based Office

Complete this form ONLY if all or part of your practice is home-based.

1. Name: _____
LAST FIRST MIDDLE INITIAL

2. Are there separate entrances for your home and office? ..... ☐YES ☐NO

3. Is there a separate patient reception room in your home office? ..... ☐YES ☐NO

4. Do you have individual treatment rooms? ..... ☐YES ☐NO

5. What equipment do you use for treatment? _____

_____

6. How many people do you have on staff? _____

7. Do you have general liability coverage for your home-based office? ..... ☐YES ☐NO

8. What percentage of your practice is based out of your home? ..... _____%

X _____ X _____
SIGNATURE DATE

NCMIC
Insurance Company

Past Claim/Incident Information

Complete this form ONLY if you have had professional liability or professional discipline incidents occur or claims brought against you.
Please make copies of this form as needed *(each claim/incident requires an individual form).*

1. Doctor's Name: _____
   LAST FIRST MIDDLE INITIAL
2. Patient's Name: _____
   LAST FIRST MIDDLE INITIAL
3. Date of incident from which claim or suit resulted or is likely to result: _____
4. Allegations made against you: _____
5. Explain, in detail, the specifics of the incident which led to the claim: _____
6. Did the incident result in a claim against you? .....☐YES ☐NO
   If "YES," please complete questions 7-12.
7. Date claim was made against you:_____
8. Present status or disposition of claim including amount reserved or amount of settlement, if any:_____
9. Please provide the following information regarding where the claim was filed.
   State: _____ County: _____
   Court: _____ Court Claim No.: _____
10. Is the claim open or closed?..... ☐ Open ☐ Closed
    If "CLOSED," please provide the following information:
    Date claim closed:_____ Loss Amount:_____
11. What insurance company was/is involved: _____
    Please attach loss information from previous insurance company at time of claim.
12. Name of doctors, hospitals, institutions or any other professionals, if any, involved in the claim or suit:

If you need additional space for claim information, please include details on a separate sheet.

X _____ **X** _____
SIGNATURE DATE

NCMIC Insurance Company

Request for Professional Entity Coverage

Please complete a separate request for each corporation/entity to be insured. All questions must be answered. If there is not enough space, please attach a separate sheet of paper with complete details including the question that you are addressing. Coverage will be effective only upon approval by NCMIC.

Section A – GENERAL INFORMATION

Name: _____
LAST FIRST MIDDLE INITIAL

NCMIC Policy Number: _____

Mailing Address: _____
STREET CITY STATE ZIP

Practice Phone: (_____)_____ Practice Fax: (_____) _____

Email Address: _____
Your email address will never be sold. It will be used to send you important messages.

Section B – CORPORATE/ENTITY INFORMATION

1. Name of entity: _____

2. Practice Address: _____
STREET CITY STATE ZIP

3. Date of Incorporation: _____ /_____ Federal Tax ID No.: _____
MO YR

4. Do you have a website? ..... ☐ Yes ☐ No
✓ **If "yes," please list website address:** _____

5. Are you the owner or the majority shareholder of this legal entity? ..... ☐ Yes ☐ No

6. Do you have malpractice coverage for this entity under another policy? ..... ☐ Yes ☐ No
✓ **If "yes," please attach a copy of that policy's declarations page.**

7. Is the purpose of your professional entity naturopathic in nature?..... ☐ Yes ☐ No
If "no," please explain: _____

8. Are there other licensed professionals practicing in this entity/office other than yourself? ..... ☐ Yes ☐ No
If "yes," please provide the requested information for each licensed individual in your office.
IMPORTANT: All licensed professionals must have malpractice coverage with equal or greater limits of liability.

Name	Designation	Insurance Company	Limits of Liability	Expiration Date

Please attach a declarations page for each individual listed above.

9. Are there other owners, officers and/or directors of the professional entity other than yourself?..... ☐ Yes ☐ No
If "yes," please provide the requested information for yourself and each officer and/or director of the professional entity. IMPORTANT: Naturopathic directors and officers must be insured with NCMIC with equal or greater limits of liability. Coverage will be added to only one policy, most often the professional entity president's policy. Please provide proof of coverage.

Name	Title	Professional Designation	Relationship to Insured (if applicable)	% of Ownership

Please attach a declarations page for each individual listed above.

Section C – SELECT YOUR COVERAGE

The following options for coverage are available – please check the coverage you desire:

☐ **Shared Limits (Not available in CT):** This provides shared limits of liability coverage for the entity at no additional cost.

☐ **Separate Limits (Group Policy):** This provides separate limits of liability coverage for the entity as well as the insureds listed on the Schedule of Insureds. The premium for this coverage will be 20% of the total undiscounted base premium for each insured listed on the Schedule of Insureds. **Important Note:** In order to qualify for this coverage, all naturopathic employees, officers, directors, and partners must be insured with NCMIC on a group policy.

☐ **Sole Practitioner (Only available in CT):** This coverage provides shared limits of liability at no additional charge to a Naturopathic Doctor's professional entity, as long as the entity does not employ any other licensed health care providers.

Section D – PLEASE READ, SIGN AND DATE

I hereby acknowledge that the aforementioned statements and answers are correct and complete to the best of my knowledge and belief.

For Residents of all States Except District of Columbia, Maine and Washington: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

District of Columbia: 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.

Maine and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

X_____ SIGNATURE

X_____ DATE

X_____ AGENT SIGNATURE

X_____ DATE

Section E – RETURN THIS FORM

Mail to:
NCMIC Insurance Company
P.O. Box 9118
Des Moines, IA 50306

Fax to:
1-800-996-2642

Scan and email to:
submissions@ncmic.com

Questions? Call toll free
1-800-952-9935