ChiroPreferred

ISSUING COMPANY:
THE MEDICAL PROTECTIVE COMPANY

HEALTHCARE PROFESSIONAL INSURANCE APPLICATION

This application is used to rate and underwrite your insurance policy ("Policy"). Medical Protective ("Company") reserves all rights to decline a claim or to rescind the Policy for any failure to complete the application questions.

FIRST NAME | MIDDLE INITIAL | LAST NAME

MAILING ADDRESS | APARTMENT / SUITE

CITY | STATE | ZIP CODE | LICENSE / CERTIFICATION NUMBER | DATE OF BIRTH (__/__/__)

PHONE (__-__-__) | EMAIL

I. GENERAL INFORMATION

A. **OCCUPATION/SPECIALTY:** _____

B. **INDICATE THE SERVICE(S) AND/OR PROCEDURE(S) THAT YOU PROVIDE:** _____

C. **PRIMARY PRACTICE COUNTY, STATE:** _____

D. **POLICY EFFECTIVE DATE:** __/__/__

E. **EMPLOYMENT STATUS:** ○ Employed ○ Self-Employed

F. **POLICY LIMITS:** Per Claim/Occurrence: $ _____ Annual Aggregate: $ _____

G. **POLICY TYPE:**

- ○ Occurrence
- ○ Claims-Made – without prior acts coverage. Retroactive date will match requested policy effective date.
- ○ Claims-Made – with prior acts coverage. Current Claims Made Retroactive Date: __/__/__
- ○ Convertible Claims-Made. Current Claims Made Retroactive Date: __/__/__

H. **HOURS WORKED PER WEEK:** _____

I. **DID YOU GRADUATE IN THE LAST 5 YEARS?** ○ Yes ○ No

Graduation Date: __/__

J. **HAVE YOU COMPLETED A RISK MANAGEMENT COURSE IN THE LAST 12 MONTHS?** ○ Yes ○ No

K. **PROFESSIONAL ASSOCIATION MEMBERSHIP(S):** _____

L. **INDICATE ADDITIONAL COVERAGES YOU WOULD LIKE TO PURCHASE:** _____

II. PROFESSIONAL INFORMATION

A. **PRIMARY EMPLOYER NAME:** _____

B. **IS YOUR PROFESSIONAL DESIGNATION/CERTIFICATION OR TRAINING CURRENTLY VALID?** ○ Yes ○ No

If no, explain: _____

C. **ARE YOU NOW, OR HAVE YOU EVER BEEN:** ○ Yes ○ No

- Charged with, convicted of, or indicted for any act committed in violation of any law or ordinance, other than traffic offenses, or have ever had your hospital privileges, DEA license, healthcare license or reimbursement privileges denied, refused, revoked, suspended, restricted, subject to a reprimand, placed on probation, or voluntarily surrendered?
- Accused of sexual misconduct of any kind?
- Aware of a health condition that could impair your ability to practice your profession? (Including addiction to alcohol, narcotics or other controlled substances.)

If yes, indicate date(s) and explain: _____

For the following questions, please include responses for all types of professional liability insurance; e.g., malpractice; general liability; cyber/privacy liability; and/or employment practices liability.

D. HAS ANY INSURANCE COMPANY EVER CANCELED, DECLINED, NON-RENEWED, OR RESCINDED A PRIOR INSURANCE POLICY? ○ Yes ○ No

If yes, indicate date(s) and explain. _____

E. ARE YOU NOW, OR HAVE YOU EVER BEEN: ○ Yes ○ No

- Involved in a claim; e.g., a demand for money;
- Involved in a lawsuit; and/or
- Aware of any complication, event, incident or adverse outcome that might reasonably result in a claim or lawsuit against you?

If yes, how many? _____

III. CLAIMS MADE NOTICE

If "Occurrence" or "Claims Made – without prior acts coverage" was selected above as the desired coverage type, and your most recent coverage was also Claims Made, please be advised the following:

- If you do not purchase "tail coverage" (an extended reporting endorsement) from your current insurer, there will be an uninsured exposure for any claims made after the termination of your current coverage based upon your conduct that took place after the retroactive date and before the termination date of your current coverage.
- If you do not purchase "tail coverage" from your current insurer, you must request that the Company provide prior acts coverage. If approved, the Company may offer prior acts coverage.
- If you do not purchase tail coverage or if the Company does not provide prior acts coverage, there will be an uninsured exposure.
- A Claims Made policy will only apply to a claim first made during the policy period, for conduct from the retroactive date to the expiration date. Please contact your agent should you have any questions pertaining to the differences between Claims Made and Occurrence coverage.

IV. IMPORTANT NOTICE – REPRESENTATIONS, AUTHORIZATIONS, RELEASES AND NOTICES

MANDATORY: ALL APPLICANTS must read the following statement:

An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act. A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

V. NOTICES AND AGREEMENTS

I further acknowledge that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I or any applicant agree that this application, and any Attachments, shall be the basis of the contract with the Company. **I agree to notify the Company if there are any future material changes in any answer to this application, or its Attachments, including without limitation, any change in professional specialty, affiliation or working arrangement with any other healthcare provider, facility, firm or professional association.**

An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act. A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

I further understand and agree that I have no right to demand or expect a Policy until the Company has: (1) received my completed application; (2) my application has been accepted by the Company; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer, credit card payment or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree and understand that if I fail to comply with these terms, I will have no Policy of insurance for which I am applying for any claim.

I also agree and understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of the Policy. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the Policy issued hereunder.

APPLICANT'S SIGNATURE	PRINT NAME	DATE SIGNED

ELECTRONIC SIGNATURE TERMS AND CONDITIONS

The Electronic Signature Terms and Conditions set forth below address the circumstances under which you agree to conduct business with ChiroPreferred. In order to transact business electronically, your consent is needed. Please review the terms and conditions below.

By initialing in the "I understand and agree to the Electronic Signature Terms and Conditions" box below, you are signing this application for insurance electronically, thereby providing your electronic signature. You agree your electronic signature is the legal equivalent of your manual signature and that your electronic signature constitutes your acceptance and agreement as if this application was signed by you in writing. Furthermore, you consent to be legally bound by all statements made by you in this application for insurance. You also agree that no certification authority or other third party verification is necessary to validate your electronic signature and that lack of any such certification or verification will not in any way affect the enforceability of your electronic signature.

System Requirements: Electronic documents are published in Hyper Text Markup Language (HTML) or Portable Document Format (PDF). By initialing in the box below, I confirm that I can access and retain documents in HTML or PDF format. In order to participate in this program, I will need an email address, Internet access, and an Internet browser that is HTML JavaScript enabled. I will be advised if there is a change in the hardware or software requirements. The revised requirements will be described and I will be given the opportunity to withdraw my consent without charge or imposition of any conditions or consequences not described below.

Receiving Email: I may provide or update my email address at any time by calling ChiroPreferred at 833-4CHIROS (833-424-4767).

Special Notice for Policyholders in the State of Kentucky: The policyholder who elects to allow for documents to be sent to the email address provided by the policyholder should be aware that the election operates as consent by the policyholder for the documents to be sent electronically. Therefore, the policyholder should be diligent in updating the email address provided in the event that address should change.

Requesting and Viewing Electronic Documents: I can view electronic documents at www.medpro.com. Without revoking my consent, I can request a paper copy of my application by calling ChiroPreferred at 833-4CHIROS (833-424-4767).

Changing Selections or Revoking Consent: My consent is effective until further notice to ChiroPreferred. At any time, I may withdraw my consent and receive paper documents, or update my email address. Even if I consent to receive documents electronically, I may request paper documents at any time at no additional cost by calling ChiroPreferred at 833-4CHIROS (833-424-4767). Documents will be provided to me in paper form at no additional charge. After I withdraw my consent, which may take up to ten (10) days to process, all future documents will be provided to me in paper form. Withdrawal of my consent will not affect the legal enforceability of any document, or result in the imposition of additional fees, conditions or consequences not previously described.

☐ I understand and agree to the Electronic Signature Terms and Conditions

SUPPLEMENTAL INFORMATION