



TEXAS MEDICAL INSURANCE COMPANY

ENCLOSED ARE THE FORMS NECESSARY FOR APPLICATION

- Applicant must be employed and supervised by a TMLT insured physician.**
- Complete and sign the *Application for Coverage*.
- Complete the *Claim/Suit Information Addendum* if a professional liability claim or suit has **ever** been brought against you.
- Copy of certificate or licensure.
- IMPORTANT! Attach a copy of your *Declarations Page* and all other pages relative to the retroactive or prior acts date of your current insurance.**
- If payment is included make your check payable to *Texas Medical Insurance Company* or *TMIC*.
- Return all applicable forms to:
P.O. Box 160140
Austin, TX 78716-0140
We encourage the return of multiple applications for one company in the same envelope.
- Include a listing of all applicants by name and profession.

Instructions regarding premium payment:

Quarterly and annual payment options will be billed by invoice and mailed to the *Named Insured*. If you choose the monthly payment option, you must complete, sign and return the enclosed *Authorization for Direct Bank Debit* along with a voided check on the account to be debited.

If you have any questions, we will be happy to assist you. Call our toll free number listed below and ask for Sales.

TEXAS MEDICAL INSURANCE COMPANY

P.O. Box 160140 • Austin, TX 78716-0140

901 Mopac Expressway South • Barton Oaks Plaza V, Suite 500 • Austin, TX 78746

Toll free: 800-580-8658 • Local: 512-425-5800 • Fax: 512-425-5998

Email: sales@tmic.biz • www.tmic.biz

Receipt by TMIC of application(s) and/or premium payment does not constitute a binder or acceptance of coverage.



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INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE
CHIROPRACTOR

PLEASE TYPE OR PRINT IN BLACK INK. ALL QUESTIONS MUST BE ANSWERED IN DETAIL.
COVERAGE WILL NOT BE CONSIDERED UNTIL THIS APPLICATION IS COMPLETED AND SIGNED.

I. GENERAL INFORMATION

Policy Number: _____
(For TMIC Use Only)

A. Contact Information

1. Name of applicant:

First Middle Last

2. Home address:

Street City State Zip

3. Preferred mailing address:

[] Home [] Principal Office [] P.O. Box # [] Other:

4. Telephone numbers:

Office Phone: (Area Code) Number Home Phone: (Area Code) Number Facsimile: (Area Code) Number

5. Other information:

Date of Birth Country of Birth Chiropractic License #/Status

B. Practice Locations

1. Please list all office locations where you currently practice or intend to practice.

List principal location first.

Number Street Suite City State Zip County

- a.
b.
c.

2. Other counties where you practice:

3. Is any of your practice outside of Texas? [] yes [] no

Where Percentage

4. Current professional memberships:

C. Enclose a copy of your current Curriculum Vitae and your Office Letterhead.
If you currently have professional liability coverage, include a copy of the Declaration Page.

II. INSURANCE COVERAGE

A. I request that my insurance commence at 12:01 a.m. on:

Month Day Year

B. Professional Liability Coverage:
Please check type of coverage (**only one**) and limits of liability desired.

- Claims-made** (Limits indicated are Each Claim and All Claims.)
- \$100,000/\$300,000 \$500,000/\$1,500,000
- \$200,000/\$600,000 \$1,000,000/\$3,000,000

I understand the unique nature of the Claims-made policy and the importance of purchasing a Reporting Endorsement (tail coverage) upon cancellation or non-renewal of this policy, if issued.

- Occurrence** (Limits indicated are Each Claim and All Claims.)
- \$100,000/\$300,000 \$500,000/\$1,500,000
- \$200,000/\$600,000 \$1,000,000/\$3,000,000

C. Insurance History

1. Indicate name, policy number, limits of liability, and expiration date of your present insurance.

Name of Insurer Policy No. Limits of Liability Expiration Date

2. On which basis is your present professional liability policy written?
- Claims-made Occurrence None carried

If my current insurance is written on a Claims-made form, I understand the necessity of purchasing a Reporting Endorsement (tail coverage) from my present insurer or Prior Acts (nose coverage) from TMIC to avoid having a gap in coverage.

If present insurance is written on an Occurrence form, proceed to Section III.

3. Have you purchased or are you planning to purchase a Reporting Endorsement (tail coverage) from your present insurer? yes no
4. If "no," are you requesting Prior Acts Coverage from TMIC? yes no
- If "yes,"
- a. Are you aware of any incidents (patient expressions of dissatisfaction or fee disputes resulting from treatment rendered) which you have reason to believe may lead to a claim or suit against you? yes no
- b. Have you reported any incidents (which have not yet resulted in a claim or suit) to your current carrier? yes no
- c. Have you received any oral or written threats of legal action, request for patient records, subpoena, petition, complaint, summons, citation, or other legal process or notification? yes no

If you answered "yes" to a, b, or c above, please provide details, including dates, in the Additional Information section on page 7 of the application.

d. What is the retroactive or prior acts date on your current policy?

Month Day Year

Please attach a copy of your current Declarations Page and all other pages relative to the retroactive or prior acts date.

III. UNDERWRITING AND RATING INFORMATION

A. Practice History

1. Education

Name

City/State

From/To

Chiropractic College _____

2. Did you participate in any continuing education programs during the past year? yes no
If "yes," total # of hours: _____ and describe:

3. Did you attend any malpractice loss prevention programs during the past year? yes no
If "yes," where? when? and describe:

4. Where have you practiced your chiropractic profession since completion of your formal training? (Include military or any public service organization.) PLEASE ACCOUNT FOR ALL TIMES SINCE COMPLETION OF YOUR CHIROPRACTIC TRAINING.

_____ From _____ To _____
City State/Country Month Year Month Year

_____ From _____ To _____
City State/Country Month Year Month Year

_____ From _____ To _____
City State/Country Month Year Month Year

B. Practice Structure

1. Organization structure

- Partnership
 Office Share/De Facto Partnership
 Solo Professional Association (Solo PA coverage is automatically provided under an individual's policy.)
 Professional Association (PA)
 Other

Describe

- Do you desire coverage for the above? yes no
If "yes," please complete the **Professional Association/Partnership Application**.

2. Type of practice

- Individual Practice
 Employee
 Independent Contractor
 Other (Please specify): _____

3. Exact name and address of Solo PA, Professional Association/Partnership, Group, HMO or Employer, etc:

Name

Street

City

State

Zip

4. Any other name under which you practice (i.e. DBA)?

C. Personnel

1. Do you Employ Supervise Contract any licensed chiropractors? yes no

Name	Insured By	Limits of Liability
------	------------	---------------------

Name	Insured By	Limits of Liability
------	------------	---------------------

Name	Insured By	Limits of Liability
------	------------	---------------------

2. Indicate number of professional licensed personnel in each category employed or supervised by you personally or by a partnership or corporation of which you are a member or shareholder.

_____ Chiropractic Assistants	_____ Massage/Physical Therapists
_____ Technicians	_____ Medical Assistants
_____ Acupuncture Technicians	_____ Nurses
_____ X-Ray Technicians	_____ Physician Assistants
_____ Nutritionists	_____ Other _____

3. Do you desire individual coverage for any of the above personnel? yes no
If "yes," please request and complete the **Health Care Professional application(s)**.

D. Patients

1. Average number of patients seen per week in your office is: # _____

2. Average number of practice hours per week involved in both direct patient care and related administrative activities is: # _____

3. Source of patient services/patient mix

a. Fee for service	_____ %
b. Pre-paid (HMO-PPO, etc.)	_____ %
• List the number of all current HMO-PPO-IPAs or similar organizations you belong to:	# _____
• List the number of contracts under which you receive capitated payments:	# _____
• Total number of capitated lives in your practice:	# _____
c. Other: _____	_____ %
d. TOTAL	100 %

E. Practice Description

Do you,

1. use homeopathic remedies? yes no

2. use video fluoroscopy? yes no

3. sell vitamins, food supplements, herbs, homeopathic remedies out of your office? yes no

4. prescribe drugs or medicine? yes no

5. practice any surgery? yes no

6. use radium or X-ray for other than diagnosis? yes no

7. perform cranial adjustments? yes no

8. perform cosmetic chiropractic? yes no

9. perform manipulations under anesthesia (MUA)? yes no

10. refer patients to physician/surgeons? yes no
11. own your own X-ray unit? yes no
age of the unit: _____
12. X-ray your own patients? yes no
13. arrange to have your patients X-rayed by others? yes no
14. take X-rays for others? yes no
If "yes," average number per week: # _____
15. take opposing views when X-raying a patient? yes no
16. use a qualified roentgenologist X-ray consultant? yes no
17. use an X-ray technician? yes no
18. Does technician have formal X-ray training? yes no
19. Have you taken any postgraduate classes for X-ray in the past two years? yes no
20. What is the average number of X-rays you take each month? # _____

Note: If any of the answers to questions 21 through 35 are "yes," details (including dates, if applicable) must be provided in the *Additional Information* section on page 7.

21. Are you entering practice for the first time immediately following chiropractic training, military service or an academic position? yes no
22. Are you an employee of or do you do any contract work for any federal, state, local or governmental agency? yes no
If "yes," please give details, including whether professional liability insurance is provided for you.
23. Do you perform acupuncture? yes no
If "yes,"
- a. Are you legally authorized to practice acupuncture at that address? yes no
- b. Where did you receive your acupuncture training and of what did it consist?
- _____
- _____
- _____
- c. Attach a copy of any specialty degree of competence and state certification issued to you.
24. Do you advertise? yes no
If "yes," please send samples of your yellow pages display ads and other media advertisements. If you use radio or television, please describe.
25. Have you ever been treated for alcoholism or any substance abuse or mental illness? yes no
If "yes," provide statement of insurability from treating physician.
26. Have you now or ever had any chronic physical defect or emotional impairments? yes no
If "yes," provide statement of insurability from your treater.

27. Have you ever had your chiropractic license restricted, revoked, suspended, or cancelled? yes no
28. (a) Is your chiropractic license under pending investigation? yes no
- (b) Have you ever voluntarily surrendered your chiropractic license during or following an investigation? yes no
29. (a) Has any HMO, PPO, or other managed care facility ever denied, restricted, suspended, or revoked your privileges? yes no
- (b) Are you currently under investigation? yes no
- (c) Have you ever terminated following a staff investigation? yes no
30. Have you ever been denied any license or certification by a board? yes no
31. Has your membership in any professional society or association ever been denied, cancelled, revoked, or censured? yes no
32. Have you ever been convicted of a crime other than a minor traffic violation? yes no
33. Have any fee complaints or professional relations complaints been registered against you with any chiropractic association or licensing authority? yes no
34. Have you ever been the subject of disciplinary proceedings or been reprimanded by an administrative agency, hospital, professional association or peer review? yes no
35. Has your professional liability insurance ever been denied, cancelled or non-renewed or do you have knowledge that your present insurer plans to cancel or non-renew your coverage? yes no
If "yes," please explain why, when and name of insurer(s).

G. Claim Information

- I. Has any professional liability claim or suit ever been brought against you? yes no
*If "yes," please provide the total number of claims and complete the information for all claims/suits in Section VI, **Claim/Suit Information Addendum** on page 8.* # _____

(Failure to provide complete information as requested will cause delay in processing your application.)

IV. AUTHORIZATION AND REPRESENTATION STATEMENT

I certify that the foregoing information is true and correct and agree that if any policy is issued, such policy will be issued in reliance upon the representations made herein.

I authorize access by, and release to, TMIC any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: any county or state professional society, association or organization; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Professional Liability Coverage. I further authorize TMIC and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

By submission of this application, or by acceptance of insurance coverage from TMIC, I hereby release TMIC and its representatives from liability for any acts or omissions in connection with any communications, investigation or decision regarding insurance underwriting investigation.

Signature of Applicant

Date

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

VI. CLAIM/SUIT INFORMATION ADDENDUM

If additional space is required, please photocopy this form as needed. Please type or print in black ink.
Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.

1. Claim/Suit Information Name of applicant: _____

Patient's Name: _____ Age: _____ Sex: _____ Date of incident: _____
(month/day/year)

Insurance company defending your claim: _____ Policy # _____

Location: City _____ State _____ Hospital _____

Procedures performed: _____

ALLEGATIONS and narrative description of the treatment and your involvement:

Co-defendants: _____

Suit filed? yes no If "yes," month _____ year _____

Court trial? yes no If "yes," month _____ year _____

Jury verdict? yes no If "yes," month _____ year _____

Settlement out of court? yes no If "yes," month _____ year _____

Claim settled without indemnity payment on your behalf

Claim is pending:

Amount in reserve by insurance company: \$ _____

Total amount paid to claimant on your behalf: \$ _____

Total amount paid to claimant for all defendants: \$ _____

2. Claim/Suit Information Name of applicant: _____

Patient's Name: _____ Age: _____ Sex: _____ Date of incident: _____
(month/day/year)

Insurance company defending your claim: _____ Policy # _____

Location: City _____ State _____ Hospital _____

Procedures performed: _____

ALLEGATIONS and narrative description of the treatment and your involvement:

Co-defendants: _____

Suit filed? yes no If "yes," month _____ year _____

Court trial? yes no If "yes," month _____ year _____

Jury verdict? yes no If "yes," month _____ year _____

Settlement out of court? yes no If "yes," month _____ year _____

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Total amount paid to claimant on your behalf: \$ _____

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