NCMIC
Insurance Company

Temporary (Locum Tenens) Request for Malpractice Insurance

In order for temporary (locum tenens) coverage to apply under this policy, the following conditions must exist:

- The Insured Naturopathic Doctor (ND) must be out of the office and have no patient contact, except for the initial training of the Temporary ND.
- Insured ND has not exceeded the 45 days allowed for coverage to a temporary fill-in within one 12-month policy period.
- No coverage will be provided if Temporary ND has malpractice insurance.
- Coverage will only be provided in the state(s) in which both the Insured ND and Temporary ND hold active licenses/registrations.

This application must be returned to NCMIC for approval prior to coverage dates needed. Please fill out all sections completely. If any areas do not apply, indicate N/A. There is no additional premium for this coverage.

Section A – INSURED ND INFORMATION

Name: _____
LAST FIRST MIDDLE INITIAL

NCMIC Policy Number: _____

Dates of Coverage Requested: _____

_____

Section B – TEMPORARY ND 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
MO. DAY YR.
6. Mailing Address: _____
STREET CITY STATE ZIP
7. Email Address: _____
Your email address will never be sold. It will be used to send you important notices.
8. Name of institution where you received your naturopathic training: _____
9. Years attended: From _____ To _____
10. Graduation Date: _____ /_____ /_____ 11. Original License/Registration Date: _____ /_____ /_____
MO. DAY YR. MO. DAY YR.
12. Year you began practicing naturopathic medicine: _____
13. List all states where you currently practice, the license/registration number, the issuance date, the date of expiration and the percentage of your practice in each state:

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

Total must equal 100% ☐

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

Section C – 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.**

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/registration ever been suspended, restricted, revoked or voluntarily surrendered, or has probation ever been invoked?..... ☐YES ☐NO

7. Has any claim or suit for alleged sexual misconduct ever been brought against you? ..... ☐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. In the past 5 years, have you been involved, directly or indirectly, in a claim or suit arising out of the rendering or failure to render professional services?* ..... ☐YES ☐NO
   ✔ **If "yes," please indicate the number of each:** Pending suits: _____ Closed claims: _____

2. Other than the situations indicated in Question 1 above, are you aware of any of the following:
   - Requests for patient records from a patient, family member, attorney or patient representative related to an adverse outcome or treatment of a patient?..... ☐YES ☐NO
   - A letter from an attorney regarding your treatment of a patient? ..... ☐YES ☐NO
   - A patient, family member or a patient representative's dissatisfaction with the outcome of a procedure, treatment or diagnosis?..... ☐YES ☐NO
   - Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? ..... ☐YES ☐NO

Section E – CLAIM INFORMATION (continued)

3. Have all circumstances listed in Question 2 above been reported to your current or prior insurance carrier? ☐YES ☐NO

✔ **If "yes," please attach a current loss run for each carrier, as appropriate.**

✔ **If "no," please explain why these circumstances were not reported:**_____

_____

_____

*For the purposes of this section the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you, any partner, associate, employee, or any professional corporation or partnership.

If you answered "YES" to any of the above questions, provide details on a Past Claim/Incident Information Form.

Section F – TREATMENT INFORMATION

1. Please indicate the percentage of your practice time for each treatment noted below:

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

Acupuncture (please complete Acupuncture Supplement) _____ %

Chelation Therapy for treatment of heavy metal toxicity

Oral _____ %

Rectal _____ %

IV _____ %

Chinese Herbal Medicine _____ %

Prolotherapy

PRP _____ %

Homeopathic solutions _____ %

Naturopathic Manipulation _____ %

Sclerotherapy for the treatment of spider veins _____ %

Midwifery, Obstetrical, Prenatal and/or Neonatal Care _____ %

Please describe:_____

_____

IV/IM Vitamin and Mineral Therapy _____ %

Do you mix your own solutions? ☐YES ☐NO

Do you refer patients out who require extravasation? ☐YES ☐NO

Pain Management (please complete Pain Management Supplement) _____ %

Please list procedures: _____

_____

Trigger Point Injections _____ %

Please describe solutions used: _____

_____

Hormone Replacement Therapy _____ %

Do you treat using bioidentical HRT pellets? ☐YES ☐NO

Testosterone Injections _____ %

Medical Marijuana _____ %

Do you sell medical marijuana in your practice? ☐YES ☐NO

If "yes," please explain:_____

_____

Other procedures not listed above:_____ _____ %

_____

Total (must equal 100%) _____ %

Section G – SIGNATURE REQUIRED

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that NCMIC Insurance Company (NCMIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

New Hampshire residents: By signing this application, I represent that the statements, information, and answers provided herein are true and accurate. I understand that NCMIC Insurance Company (NCMIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

Acceptance of the premium does not constitute approval of the application. By signing this application the applicant authorizes NCMIC to conduct any and all background investigations in support of this application of insurance.

For Residents of all States Except Colorado, Maine, Maryland, Pennsylvania, Washington and District of Columbia: 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.

Colorado: 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.

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.

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

Pennsylvania: 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.

X _____	X _____
SIGNATURE OF INSURED ND	DATE
X _____	X _____
SIGNATURE OF TEMPORARY ND	DATE
X _____	X _____
AGENT SIGNATURE	DATE

Section H – 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

The Naturopathic Malpractice Insurance Plan is offered through NCMIC Diversified Health RPG Assn. Coverage is underwritten by NCMIC Insurance Company.