NCMIC
Insurance Company

State-to-State Transfer Request

Please complete all questions and provide any additional requested documentation as indicated. If your answer to any question is "NONE" or "NOT APPLICABLE," please write "N/A."

Section A – GENERAL INFORMATION

1. Name: _____
   LAST FIRST MIDDLE INITIAL

2. NCMIC Policy Number: _____

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

4. 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.**

5. Practice Address: _____
   STREET
   _____
   CITY STATE COUNTY ZIP

6. Home Address: _____
   STREET
   _____
   CITY STATE ZIP

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

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

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

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

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

12. Website Address: _____

Section A – GENERAL INFORMATION (continued)

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:

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

Total must equal 100% ☐

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

Section B – COVERAGE INFORMATION

1. 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.

2. 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:

- Colorado - ONLY limits available:
  ☐ $1 million/$3 million
- 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 <u>including paperwork</u>?..... ☐YES ☐NO
   a. Number of hours per week in direct professional work with patients: _____
   b. Total number of patients you see weekly: _____

Section D – 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 E – 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.

Continued →

Section E – SIGNATURE REQUIRED (CONTINUED)

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 _____ SIGNATURE X _____ DATE

X _____ AGENT SIGNATURE X _____ DATE

Section F – RETURN THIS FORM

Mail to:	**Fax to:**	**Scan and email to:**	**Questions? Call toll free**
NCMIC Insurance Company P.O. Box 9118 Des Moines, IA 50306	1-800-996-2642	submissions@ncmic.com	1-800-952-9935

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

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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

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.

X _____ **X** _____
ACCOUNTHOLDER SIGNATURE DATE

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

X _____ X _____
AGENT SIGNATURE DATE