

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 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 – TREATMENT INFORMATION

1. Please indicate the percentage of patient encounters you perform 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:
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

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 Quarterly Tri-Annually
(not available in CT) (not available in CT) (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



CT Request to Add the Employee Endorsement

SECTION A – GENERAL INFORMATION

Name: _____
LAST FIRST MIDDLE INITIAL

NCMIC Policy Number: _____

Mailing Address: _____
STREET

CITY STATE ZIP

Office Phone: (_____) _____ Fax: (_____) _____

Home Phone: (_____) _____ Email Address: _____
Your email address will never be sold. It will be used to send you important notices.

SECTION B – REQUEST TO ADD EMPLOYEE COVERAGE

- Yes**, please add the Employee Endorsement to my policy listed above. I understand there is an additional charge of 10% of my basic premium to add coverage for my unlicensed ancillary staff and licensed massage therapists. This Endorsement will be effective on the day following receipt of this form by NCMIC.
- No**, I do not want to add the Employee Endorsement to my policy. I understand there is no coverage under my policy for any employees.

SECTION C – PLEASE READ, SIGN AND DATE

I understand that unless and until this form is returned to NCMIC Insurance Company electing in favor of the Employee Endorsement, no coverage for my employees is in force.

Also, I have no knowledge of any claims or incidents of potential malpractice which may have occurred that I have not yet reported to any insurance carrier.

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.

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.

X _____ **X** _____
SIGNATURE DATE

X _____ **X** _____
AGENT SIGNATURE DATE

SECTION D – PLEASE READ, SIGN AND 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