

Please complete all information below. Along with this application, send a letter from your state licensing board or college showing that you are involved in the Extern Program. The supervising Naturopathic Doctor must be insured with NCMIC. Limits of liability will be shared with the supervising Naturopathic Doctor's limit; a separate limit does not apply. Premium must be received in full before the policy can become effective. The premium for this endorsement will be 10% of the base rate. Coverage will be effective only upon receipt of your Request for Coverage and approval by NCMIC.

Section A – GENERAL INFORMATION

Applicant Name: _____
LAST FIRST MIDDLE INITIAL

Mailing Address: _____
STREET CITY STATE COUNTY ZIP

Last four digits of your Soc. Sec. No.: _____ Male Female

Date of Birth: ____/____/____ Date of Graduation: ____/____/____

Naturopathic College Attended: _____

Proposed Effective Date (*Date the application is received at NCMIC or later if specified*): ____/____/____

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

Section B – PRACTICE INFORMATION

Name of Supervising Doctor: _____
LAST FIRST MIDDLE INITIAL

Practice Address: _____
STREET CITY STATE COUNTY ZIP

Practice Phone: (_____) _____ Practice Fax: (_____) _____

Section C – PLEASE READ, SIGN AND DATE

I understand that I am limited to practice at the office of the above mentioned supervising doctor and must be directly under the supervision of the Naturopathic Doctor. Coverage will end on the earliest of the following: 1) Termination of extern program; 2) Licensure; 3) One year from the effective date of the extern policy.

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.

California Residents: 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.

Washington Residents: 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.

X _____ X _____
SIGNATURE DATE

X _____ X _____
AGENT SIGNATURE DATE

Section D – 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
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