SIMED

Application for Claims Made Naturopaths Professional Liability Insurance Policy

This Application must be typed or completed in ink and signed and dated by the applicant. The information provided by you must be legible. Coverage is available to all qualified applicants as they are defined in the Article 41.020 of Chapter 41 of the Insurance Code of Puerto Rico.

Please answer every question fully and include any supporting or requested documents, and any additional information you feel may of assistance to the Underwriter such as Brochures, office letterhead, etc. Should there be insufficient spaces in the application form for full details, please attach further information on signed and dated sheets, wherever possible following the same format and question number.

If your application is approved by the Syndicate, the coverage can be provided with an inception or commencement date no earlier than the day SIMED receive the payment of the quoted premium. Under the claims made policy form, coverage is only provided for claims against the Insured arising out of medical incidents that occur on or after the Retroactive Date stated in the policy and which are reported in writing to the Syndicate while the policy is in effect, unless additional reporting period coverage is purchased which would provide an unlimited time period to report covered claims. During the first three policy years claims made premium are lower and they increase gradually, independent of overall rate increase, until the claims made risk reach maturity at fourth year. The premium may also be affected due to your past loss/claims experience information.

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simedpr.com

PO Box 8969
San Juan, PR 00910

Application for Claims Made Naturopaths
Professional Liability Insurance Policy

I. Personal Information

1. Name of Applicant: _____
(First) (Middle) (Father Last Name) (Mother Maid Name)

2. Gender: ☐ Male ☐ Female

3. Mailing Address: _____

_____

4. Work or Professional Office Address: _____
No. Street

_____
City State Zip Code

5. Home Address: _____
No. Street

_____
City State Zip Code

6. Office Telephone Number: _____ Fax Number: _____
Work Telephone Number: _____
Home Telephone Number: _____ E-Mail Address: _____
Mobile Phone Number: _____ Website Address: _____

7. Date of Birth: _____ _____ _____ Place of Birth: _____
Mo. Day Yr.

8. Social Security No: _____

9. Are you duly registered and licensed to practice your profession in the Commonwealth of Puerto Rico? ☐ Yes ☐ No

License No: _____ ☐ Naturopath ☐ Doctor in Naturopathy
Date Issued: _____ Expiration Date: _____

Provide a certification issued to SIMED by the corresponding Licensing Board indicating that your license is in force and have never been suspended or revoked. Attach a copy of your license.

10. Professional school and location from which you graduated _____
Location: _____ Degree _____ Year of graduation: _____

11. Name of institution where you received your naturopathic training:

Name of School/Institution _____
City/State/Country _____
Type of Training and Degree _____
From _____ To _____

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II. Practice/Rating Information

1. Please specify the type of coverage you are applying for:
   a. Primary Policy Limits
   ☐ $100,000 per medical incident/$300,000 aggregate
   b. Excess over primary policy limits
   ☐ $150,000 per medical incident/$300,000 aggregate
   ☐ $400,000 per medical incident/$800,000 aggregate
   ☐ $650,000 per medical incident/$1,300,000 aggregate
   ☐ $900,000 per medical incident/$2,700,000 aggregate

2. When you began the practice as Naturopath? _____

3. What is the nature of your current practice? _____

   ☐ Solo Practitioner
   ☐ Solo or Single Professional Corporation (PC) **(If yes, please complete the attached Exhibit 1 and Exhibit 2.)**
   ☐ Multi Professional Corporation (PC) **(If yes, please complete the attached Exhibit 1 and Exhibit 2.)**
   ☐ Independent Contractor
   ☐ Professional Association (P.A.) **(Provide details on the attached sheet for this purpose.)**
   ☐ Professional Partnership **(If yes, please complete the attached Exhibit 1 and Exhibit 2.)**
   ☐ Other **(Describe or provide details on the attached sheet for this purpose.)**

4. Do you or does your partnership or corporation or association have employees?
   ☐ Yes ☐ No (**If yes, please complete the attached Exhibit 2.)**

5. Please list in the attached **Exhibit 6** all institutions you would like SIMED send certificate of insurance if a policy is issued.

6. Do you research, use, administer, or prescribe any drug, pharmaceutical or medical device disapproved or not yet approved for marketing by the United States Food and Drug Administrative for treatment of human beings (including any FDA approved studies/investigations)?

   ☐ Yes ☐ No **(If yes, please explain on the attached sheet for this purpose.)**

7. Have you signed or will you sign any contract or agreement to assume the liability of others?

   ☐ Yes ☐ No **(Please be aware that you won't be covered under the policy, if issued, for the liability of others which you have assumed under a contract or agreement.)**

8. Do you keep documented records on all patients?
   ☐ Yes ☐ No

9. Do you require or signed informed consent prior to treating all patients?
   ☐ Yes ☐ No

10. List all health oriented professional associations to which you belong:

    _____

    _____

11. Are you engaged in any other business or profession other than Naturopathy?

☐ Yes ☐ No

If yes, please explain: _____

_____

12. How many hours per weeks do you dedicate to professional services relating to naturopathy? _____

13. Please check each of the following techniques, therapy or treatment modalities you use or intend to use in your practice:

☐ Acupuncture	☐ Chelation Therapy
☐ Chinese Traditional/Medicine	☐ Acupressure
☐ Iridology	☐ Balneotherapy
☐ Aromatherapy	☐ Kinesiology
☐ Botanical/Herbal Medicine	☐ Ayurveda
☐ Therapeutic Massage	☐ Homeopathy
☐ Colonic Irrigation	☐ Music Therapy
☐ Magnetic Therapy	☐ Colour Therapy
☐ Polarity Therapy	☐ Chrome therapy
☐ Crystal Therapy	☐ Reflexology
☐ Other (Please Specify) _____	

Provide the certification issued by the corresponding Licensing Board if required.

14. Indicate average number of patients seen daily: _____

15. Does your practice entails the provision of services, perform any procedure, which you have reason to be aware that are usually provided or performed by physicians licensed as specialists or licensed in a specialty different than yours?

If yes, explain in detail: _____

_____

IV. Claims/Rating Information

The applicant must provide a loss run or loss experience report with all previous insurers. The report must be attached to this application for insurance.

1. Has any claim or suit for any alleged malpractice ever been brought against you?

☐ Yes ☐ No

(If yes, answer the following and complete the attached Exhibit 7.)

a. How many claims pending? _____
b. How many claims close without payment? _____
c. How many claims close with payment? _____

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V. Coverage Information

1. Please indicate, on what date do you wish the coverage insurance to be effective (inception date)

   _____ _____ _____
   Mo Day Yr
   12:01 a.m. Standard Time

2. Have you ever practiced without insurance? ☐ Yes ☐ No
   If yes, please explain _____

3. Please provide the following information pertaining to your past years of professional liability insurer:

From	*To*	*Previous Insurance Carrier*	*Policy Limits*	*Premium*	*Retroactive Date*

4. Do you have an excess or umbrella professional liability or a primary policy in force with other insurance company?
   ☐ Yes ☐ No

   If it is affirmative, please provide insurer's name: _____,

   Policy period: _____ _____, Retroactive Date: _____,
   From (Mo/Day/Yr) To (Mo/Day/Yr)

   Policy No: _____, Limits of liability: _____ and Policy Form No. _____.

5. Have you ever had a professional liability insurance that has been declined, cancelled, issued on special terms, or not renewed? ☐ Yes ☐ No
   (If yes, give full details.) _____

   _____

VI. Other Underwriting Information

	Yes	No
1. Are you in active United States military service?	☐	☐
2. Are you employed full time by the Federal Government (but not in active United States military service)?	☐	☐

3. Will you be performing activities which will be covered by another professional liability policy?

   If yes, are you an: ☐ Employee ☐ Independent Contractors
   Location _____ Name of Insurer _____

	Yes	No
4. Do you have contract as a provider of the Puerto Rico Government Health Plan?	☐	☐

5. Are you enjoying some kind of statutory immunity in any health facility in which you provide professional services? **If yes, indicate the name and location of the facility and explain.**

   Name of health facility _____; Location _____

6. Do you own or operate any hospital, sanitarium or clinic with bed and board facilities, laboratory, or other business enterprise?	☐	☐

(Please note that you will not be covered for your liability as a proprietor, superintendent, partner, hospital administrator, officer, stockholder or member of the board of directors, trustees or governors of any hospital, sanitarium, clinic with bed and board facilities, nursing home laboratory or other business enterprise.)

Name of the health care entity: _____

7. Has your professional license ever been suspended, revoked or restricted, renewal refused or accepted on special terms, or have you ever voluntarily surrounded the same?	☐	☐
8. Have you ever been placed on probation by any licensing board?	☐	☐
9. Have you ever been convicted of a criminal offense other than a motor vehicle violation?	☐	☐
10. Has your membership in any professional society ever been refused, suspended or revoked?	☐	☐
11. Have you had a problem with or been treated for alcoholism, narcotic addiction or mental illness?	☐	☐
12. Have you now or have you ever had a chronic illness or physical defect that impairs or could impair your ability to practice your specialty?	☐	☐

If answer to any of the above questions is yes, please give full details on the attached sheet for additional details making reference to the question involved.

IMPORTANT: To consider this application the below certification and release must be signed by the applicant.

CERTIFICATION AND RELEASE

The applicant:

1. Understands and accepts that this application does not bind the applicant or the Syndicate to complete the insurance, but it is agreed that this form shall be the base of the contract, should a policy (ies) be issued, and it will be attached to and made part of this policy (ies). The applicant agrees that if the information supplied on this application changes between the date of this application and the time when the policy (ies) is issued, the applicant will immediately notify the Syndicate of such change.

2. **I Understand and accept that signing this application and tendering premium does not bind or obligate the Syndicate to grant the limits of liability of the policy (ies) as requested. If the Syndicate determines that the applicant is eligible for the limits, the corresponding quote indicating the premium will be provided.**

3. **Understands and accepts that the policy (ies) applied for provides coverage on a claims made basis for only those claims that are made against the insured while the policy(ies) is in force, but arising out of a medical incident occurring on or after the retroactive date to be stated in the Declarations Page of the policy (ies), if issued.**

4. **Understands and accepts that coverage ceases with the termination of the policy or policies unless options available are exercised according to its terms.**

5. **Certifies that he or she is duly registered and certified by the corresponding Naturopath or Doctors in Naturopathy Board for the professional specialty and/or specialties he or she engages in, as indicated in this application and, therefore, understands and accepts that the coverage provided by the policy (ies) applied for is exclusively limited to his or her professional practice pertaining only to the registered specialty to which he/she has been authorized and certified.**

6. **Grants permission to the Syndicate to request information regarding his or her professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which he or she currently has been granted privileges and/or formerly has had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.**

   The information requested may include otherwise privileged or confidential material relative to his or her professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the underwriting procedures. The applicant releases and agrees to hold harmless the Syndicate and its representatives, employees and agents which may result from the gathering or legal use of such information to evaluate the issuance of the requested policy (ies).

7. **Hereby authorizes the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which he or she currently has or formerly has had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities and present and past employers to submit information requested by the Syndicate including otherwise privileged or confidential material relative to his or her professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the underwriting procedures. The applicant hereby further releases and agrees to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information.**

8. **Grants permission to the Syndicate to disclose to any institutions as to which I have admitting privileges or other medical relationship, any matter involving a pending or closed claim, cancellation or non-renewal of medical malpractice insurance, or any other matter which could reasonably be expected to affect the interest of such institutions as to any insurance which the Company may provide, and to disclose any information which the Company may be required to disclose by law or regulation.**

9. **Understands that any person who knowingly renders a false report, makes a misrepresentation of facts or includes in any application for insurance any matter which such person knows is untrue, commits a fraudulent act and is in violation of section 12.190 of the Insurance Code of Puerto Rico and certifies that the foregoing answers and statements are complete, true and correct to the best of his or her knowledge and belief.**

AVISO IMPORTANTE

El Artículo 27.320 del Código de Seguros de P.R. dispone lo siguiente:

"Cualquier persona que a sabiendas y que con la intención de defraudar presente información falsa en una solicitud de seguro o, que presentare, ayudare o hiciere presentar una reclamación fraudulenta para el pago de una pérdida u otro beneficio, o presentare más de una reclamación por un mismo daño pérdida, incurrirá en delito grave y convicto que fuere, será sancionado, por cada violación con pena de multa no menor de cinco mil (5,000) dólares, ni mayor de diez mil (10,000) dólares o pena de reclusión por un término fijo de tres (3) años, o ambas penas. De mediar circunstancias agravantes, la pena fija establecida podrá ser aumentada hasta un máximo de cinco (5) años; de mediar circunstancias atenuantes, podrá ser reducida hasta un mínimo de dos (2)".

IMPORTANT WARNING

Article 27.320 of the Insurance Code of P.R. arranges the following:

"Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, or will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with pain of no smaller fine of five thousand (5,000) dollars, nor greater of ten thousand (10,000) dollars or imprisonment by a fixed term of three (3) years, or both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2)".

_____ _____

Applicant's Signature **Date**

Authorized Representative or Broker Name: _____

Telephone Number: _____

Mobile Phone Number: _____

Fax Number: _____

Website Address: _____

Mail Address: _____

Exhibit 1
Partnership/Corporations

The professional Liability Coverage Partnership/Corporation will not be provided unless specifically approved by the Syndicate. Review of this application creates no obligation upon the Syndicate. The Syndicate reserves the right to issue a policy to the Partnership/Corp. Liability to provide this coverage. The Partnership/Corp. Liability coverage will be secondary to any professional liability policy that insures any natural or legal person other than the Insured for the loss covered by the Partnership/Corp. Liability policy.

1. ☐ Single Professional Corp. ☐ Multi-Professional ☐ Partnership

   ☐ Insured by SIMED ☐ Insured by other company

   Give the name and address of the professional partnership or corporation.

   _____

   If it is a partnership, include copy of partnership agreement that states the share in the profit and losses of each partner. If it is a corporation, include copy of the certificate and articles of incorporation to this application for insurance. If it's insured by other company, provide the name of the professional liability insurance carrier and the policy number.

   _____

2. Does your partnership or corporation provide services to any health facility ☐ Yes ☐ No
   If yes, please indicate name(s).

   _____

3. List all partners, members or stockholders that participate with you in the professional partnership or corporation, their specialties, professional licenses, insurance carrier and policy number.

Name	Specialty	Puerto Rico Professional License Number	Insurance Carrier Policy Number

_____ _____ _____

Name of Applicant Signature Date

Exhibit 2
Employees Information

1. **Provide copy of the contract and licenses for each one of your employees, or employees of the partnership or corporation.**

2. If you, your medical partnership or medical corporation employs any health care professionals listed above, please indicate the individual's name, specialty and insurance carrier below:

Name	Employed or Self-employed	Professional License No. (If Applicable)	Specialty	Insurance Carrier	Employed or Contracted by:	
					Applicant	Partnership or Corp.

Provide copy of the contract and licenses for each employed health care professional.

Name of Applicant _____ Signature _____ Date _____

Exhibit 3

List hospital or clinics you would like SIMED sent certificate of insurance:

1. Name _____ Telephone _____

   Mailing Address _____

   E-mail _____

   Contact Name _____

2. Name _____ Telephone _____

   Mailing Address _____

   E-mail _____

   Contact Name _____

3. Name _____ Telephone _____

   Mailing Address _____

   E-mail _____

   Contact Name _____

4. Name _____ Telephone _____

   Mailing Address _____

   E-mail _____

   Contact Name _____

5. Name _____ Telephone _____

   Mailing Address _____

   E-mail _____

   Contact Name _____

Name of Applicant	Signature	Date

Exhibit 4
Claims Information

Please supply the following information regarding any claims or suit against you weather dismissed, settled out of court, judgment or pending. This form should be photocopied and filled out separately for each claim.

1. Name of Patient _____
2. Allegation _____

   _____

   _____

   _____

   _____
3. Date of incident leading to allegation _____
4. Claim No. and/or Civil Case No. _____, _____
5. Date claim was made or filed _____
6. Insurance Company defending you _____
7. Indicate the status or disposition of the Claim or Complaint:

   Pending ☐ (Provide copy of the extrajudicial claim or the suit and summons.)

   a. Insurer's loss reserve _____ Loss adj. expense reserve _____

   Closed ☐

   a. Exact date closed _____
   b. Total settlement or judgment _____
   c. Amount paid on your behalf _____

_____	_____	_____
Name of Applicant	Signature	Date

Sheet for Additional Details

Name of Applicant | Signature | Date

Sheet for Additional Details

Name of Applicant | Signature | Date