“Acupuncture Plus”

Malpractice Policy

To be considered for coverage complete the attached application and forward to:

William H. Scott III, CIC

Scott Danahy Naylon Co., Inc
300 Spindrift Drive
Amherst, New York 14221

1-800-728-6362 Ext: 5158

Fax (716) 633-4306

E-Mail: bscott@sdnins.com

SCOTT DANAHY NAYLON COMPANY, INC.

Thank you for your interest in our Professional Liability Program. The coverage is underwritten by Allied Professional Insurance Company, A Risk Retention Group, Inc. better known as the American Acupuncture Council (AAC).

We are offering a Claims Made or Occurrence policy. The policy limits are $1,000,000 per claim/$3,000,000 total policy limit at annual premiums as follows:

BASE RATES	CLAIMS MADE FORM	OCCURRENCE FORM
First year Practitioner	$550	$592
Second year Practitioner	$760	$827
All others	$900	$984
Part time Practitioner	$550	$592

Please complete the application in its entirety. It is very important to have an exact effective date for your policy to start, and note that we **must receive your application in our office prior to the desired effective date.**

When returning your completed application, please also include:

1. A check payable to the American Acupuncture Council for the full annual premium OR if paying by credit card, the appropriate information completed on the application.
2. **A copy of your current policy's Declaration Page (if applicable).**

If you have any questions or need additional information, please don't hesitate to give our office a call.

Sincerely,

William H. Scott III, CIC
Acupuncture Program Manager

300 Spindrift Drive, Amherst, New York 14221 phone 800-728-6362 fax 716.633.7141 web www.sdnins.com

SCOTT DANAHY NAYLON COMPANY, INC.

Acupuncture Professional Liability Insurance

Program Coverage Benefits

- Professional, fast & friendly service.
- Both “Claims-Made” and “Occurrence” policies are available.
- $1,000,000 per claim and $3,000,000 annual aggregate coverage limits.
- No deductibles.
- Prior Acts coverage available with proof of current insurance.
- “Entity Coverage” available.
- No “Arbitration Agreements” necessary.
- Special rates for new licensees aimed to help you get your practice started.
- Part-time coverage available for individuals working 20 hours or less per week.
- Coverage includes Oriental & Herbal Medicine.
- Coverage available for students/internship.
- Massage & Physical Therapy coverage available.
- Injection Therapy coverage available.
- College faculty credits.
- Premium waiver for medical-leave period.
- Access to our exclusive “Acu-Pac Program” for your Business Owners Liability policy.
- Competitive rates.

Claim-Made Policy		Occurrence Policy	
❖ First Year Practitioner:	$550	❖ First Year Practitioner:	$592
❖ Second Year:	$760	❖ Second Year:	$827
❖ All Other:	$900	❖ All Other:	$984
❖ Part Time:	$550	❖ Part Time:	$592

Scott Danahy Naylon Program Department

1 (800) 728-6362

300 Spindrift Drive, Amherst, New York 14221 phone 716.633.3400 fax 716.633.7141 web www.sdnins.com

AMERICAN ACUPUNCTURE COUNCIL

Application *for* Membership

Contact and Practice Information:

Full Name (First, Middle, Last) _____ Practice / Clinic Name _____

Office Address (include Suite #) _____ City _____ State _____ Zip _____

Mailing Address – If Different from Office Address _____ City _____ State _____ Zip _____

Office Phone _____ Alternate Phone (Home, Cell, etc.) _____ Fax _____ Email _____

Acupuncture License Number(s) _____ State Issued _____ Date Issued _____ Acupuncture College and Location _____ Year Graduated _____

Birth Date _____ Gender: ❒Male ❒Female

Fax or Mail Completed App & Payment to:

SCOTT DANAHY NAYLON LLC

300 Spindrift Drive
Amherst, NY 14221
www.sdnins.com

Phone: 800-728-6362 / 716-633-3400
Fax: 716-633-4306
Email: acupl@sdnins.com

Payment Detail (See Coverage Options page for choices)**:**

Installment Due: ----------

Optional Additional Insured (5%) ----------

Total Payment Remitted _____

Credit Card Payments, Complete Following:

Card Type: ❒ Visa ❒ MasterCard ❒ American Express

Card #: _____

Expires: _____

You are hereby authorized to charge my credit card for the amount indicated for liability coverage through the American Acupuncture Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: _____

AMERICAN ACUPUNCTURE COUNCIL

Membership Application

Professional Information *(Attach Additional Sheets When Needed)*

1. Is your acupuncture license current? ❒Yes ❒No
2. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If *Yes*, attach explanation) ❒Yes ❒No
3. Has any agency or association ever investigated or taken any action against you or your license? (If *Yes*, attach explanation) ❒Yes ❒No
4. Have you ever had malpractice insurance denied, canceled, or accepted on special terms? (If *Yes*, attach explanation) ❒Yes ❒No
5. Have you ever used any intoxicant, narcotic, or other psychoactive drugs which interfered with your ability to perform professional duties; or have you used any illegal drug in the past year? (If *Yes*, attach explanation) ❒Yes ❒No
6. Have you been convicted of violating any law other than a minor traffic offense? (If *Yes*, attach explanation) ❒Yes ❒No
7. Do you treat cancer or epilepsy? (If *Yes*, attach explanation) ❒Yes ❒No
8. Do you practice obstetrics or colonics? (If *Yes*, attach explanation) ❒Yes ❒No
9. Do you ever administer anesthesia (other than topical or by means of local infiltration)? (If *Yes*, attach explanation) ❒Yes ❒No
10. Do you ever prescribe or dispense any prescription drugs? (If *Yes*, attach explanation) ❒Yes ❒No
11. Do you always maintain the needle shaft in a sterile state prior to insertion? (e.g. after removing a needle from sterile packaging) ❒Yes ❒No
12. Do you use disposable needles? ❒Yes ❒No If *Yes*, do you use them for one insertion only, then throw them away? ❒Yes ❒No
13. Do you ever use reusable needles? ❒Yes ❒No If *Yes*, do you always follow state guidelines for sterilization of needles? ❒Yes ❒No
14. Are your needles approved by the U.S. Food and Drug Administration? ❒Yes ❒No
15. Do you perform cosmetic or facial rejuvenation acupuncture? (If *Yes*, we will send you free information to help protect your practice.) ❒Yes ❒No
16. Do you use any technique not currently taught in the acupuncture schools and colleges? (If *Yes*, attach explanation) ❒Yes ❒No
17. Do you make a differential diagnosis? ❒Yes ❒No If *No*, do you limit your responsibility to treating symptoms? ❒Yes ❒No
18. Do you always require your patients to sign an informed consent prior to treatment? (If *Yes*, attach copy of the form you use) ❒Yes ❒No
19. Do you always record the patient's account of his or her progress? ❒Yes ❒No ❒No, but I will do so now.
20. Do you always record objective findings? ❒Yes ❒No ❒No, but I will do so now.
21. Do you always record details of treatment procedures? ❒Yes ❒No ❒No, but I will do so now.
22. When a patient needs treatment or diagnosis outside your scope of practice, do you refer them to other health providers? ❒Yes ❒No
23. How many patients do you see weekly? _____ How many hours / week do you spend professionally with patients? _____
24. What is the average time you spend professionally with a patient on their first office visit? _____ Follow up visit? _____
25. Do you treat Medicaid/Medi-Cal patients? ❒Yes ❒No *If Yes*, what % of your practice is Medicaid/Medi-Cal? _____
26. List any practice management company you have used *(If none, indicate so)*: _____
27. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If *Yes*, attach explanation) ❒Yes ❒No
28. Have you ever treated a person that was previously in a research program you sponsored? (If *Yes*, attach explanation) ❒Yes ❒No
29. Who provides your current acupuncture malpractice policy? _____ Expires: _____
30. Your Acupuncture insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____
31. List any other professional healthcare license you hold (M.D., D.C.., RN, RPT, etc.): _____
    Indicate your malpractice carrier for that other profession: _____ Expires: _____
32. Which best describes how you practice: ❒Sole Proprietor ❒Professional Corp. ❒Partnership ❒Employee ❒Contractor

AMERICAN ACUPUNCTURE COUNCIL

Membership Application

33. To add your corporation, partnership, landlord, or other entity as an Additional Insured, list below, then check whether you require the Additional Insured to have a shared limit (5% cost), or separate limit (20% cost). Add sheets as needed:

_____ (Name of Additional Insured) Limits: ❒ Shared ❒ Separate

_____ (Name of Additional Insured) Limits: ❒ Shared ❒ Separate

34. Provide the names and practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT, etc.) of any healthcare practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (Attach additional sheets if needed):

_____ _____ _____ _____

35. List any current acupuncture specialty designations / certifications held: _____

36. List any acupuncture awards, teaching appointments, or published works: _____

_____

37. If you have held hospital privileges or completed a residency, provide the following (Attach additional sheets if needed):

_____ (Hospital Name and Location) _____ (Dates Affiliated) _____ (Nature of Privileges / Reason for Termination)

38. List pre-acupuncture college education: _____ (College) _____ (Yr Graduated) _____ (Degree)

➢ Signatures - Member Application for Coverage *(Signatures are required in all **FOUR** places below)*

NO FALSE STATEMENTS: I hereby declare that the above statements are true, and I have not misstated or suppressed any facts. I agree and understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of, my policy.

1. Sign here: _____ **Date:** _____

CLAIMS-MADE ONLY *(Does not apply if your Claims Reporting Basis is Occurrence):* I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the insured or insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless the insured purchased an Extended Coverage Policy within 30 days after termination.

2. Sign here: _____ **Date:** _____

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe acupuncture practices may be based in part on information provided by me in the future or during future pre-arranged office inspections. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

3. Sign here: _____ **Date:** _____

RELEASE OF INFORMATION: I hereby authorize release of information from my professional acupuncture associations & organizations, any hospitals or insurance carriers, my State Board of Acupuncture Examiners, and any other relevant entity to: the American Acupuncture Council or its agent, for any underwriting or claim-related inquiry. I agree that the organization releasing such information shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors, omissions or mistakes contained therein. A photocopy of this Release Form will be as valid as the original.

4. Sign here: _____ **Date:** _____

SCOTT DANAHY NAYLON COMPANY, INC.

Coverage Comparison

An ***occurrence policy*** provides coverage for any incident that occurs during the policy period regardless of whether or not the policy is still in effect at the time the claim is made. An advantage of the occurrence coverage form is the certainty that a claim will be covered if the incident from which the claim arose occurred during a time when insurance was in place. Also, there is no need to obtain additional coverage upon termination of coverage as would be necessary with a claims-made policy.

A ***claims-made policy*** provides coverage for claims that occur subsequent to the retroactive date and reported to the insurer while the policy is still in force. The retroactive date is the first date on which an incident may occur and be covered by the policy; usually the date the policy was initially purchased (1st policy effective date). It is important to understand the concept of claims-made insurance coverage, in order to prevent potential gaps in coverage.

The major difference between occurrence and claims-made coverage forms is that with the occurrence form, claims do not have to be reported before the termination of the insurer-insured relationship, under the claims-made form, they do; unfortunately, it may not be possible to do so. Therefore, to ensure coverage of incidents that occurred prior to termination but were reported after expiration of the last policy period, the insured must purchase either an extending reporting endorsement, commonly known as "tail" coverage, from the former insurer, or prior acts coverage with the new insurer. This endorsement in effect converts a claims-made policy to an occurrence policy by extending coverage to include those claims that occurred previously, no matter when they are reported.

Initially, occurrence coverage may appear to be more costly than claims-made. The cost of a claims-made policy changed during the first few years of coverage as the policy matures, with the cost of the first year being the lowest and increasing each year until the 5th year, when it is considered mature. The price of a claims-made policy is initially more attractive, due to the discounts in the first 4 years, but keep in mind that there is a cost involved if "tail" coverage needs to be purchased. After a number of years under either program the premium differences tend to be immaterial.

I have read the description of the two forms and elect to purchase:

_____ **An Occurrence Form Policy**

_____ **A Claims Made Form Policy**

If your current coverage is a Claims Made Form and you are now requesting an Occurrence Form policy, you need to purchase "tail" coverage from your current carrier. If "tail" coverage is not purchased and a claim is filed from the period you were covered by a Claims Made policy, the claim will not be covered by either policy.

(Signature) (Date)

APPLICATION ADDENDUM
REQUESTING ADJUSTED RATE FOR PART-TIME PRACTICE

1. Name of Insured: _____

2. Please indicate the number of **Days / Week** worked at practice: _____

3. Please indicate the number of **Hours / Week** worked at practice: _____

4. Please provide your office hours for each day of the week:

   Monday: _____ hours

   Tuesday: _____ hours

   Wednesday: _____ hours

   Thursday: _____ hours

   Friday: _____ hours

   Saturday: _____ hours

   Sunday: _____ hours

5. Indicate the approximate number of patients you see weekly: _____

6. Please provide any additional information you feel would be useful to underwriting in validating your part time status:

_____

_____

_____

_____

Sign Here: _____ **Date:** _____

Based on the above information, underwriting will determine your eligibility for Part-Time Status in connection with your Professional Liability Coverage.

AUTO PAY AUTHORIZATION

PROFESSIONAL LIABILITY INSTALLMENT PAYMENT

Installment Option (*Select one*)**:**

Name of Insured: _____

Installment Type: ☐ Annual ☐ Quarterly

Installment Amount: _____ (From Renewal Application)

Auto Pay Option (*Select one*)**:**

☐ **Bank Auto Pay (Attach Voided Check)**

Account Type: ☐ Checking ☐ Savings (select one)

Account #: _____

Bank Name: _____

Bank Routing #: _____

Branch City / State: _____

☐ **Credit Card Auto Pay**

Credit Card #: _____ (Visa, MasterCard, AMEX)

Expiration Date: _____

Authorization and Continuing Effect: Based on the Auto Pay Option I have selected, I hereby authorize the above account to be debited, or credit card to be charged, for the installment type selected; and I grant authority to initiate future debit entries as indicated until I have cancelled such authority in writing.

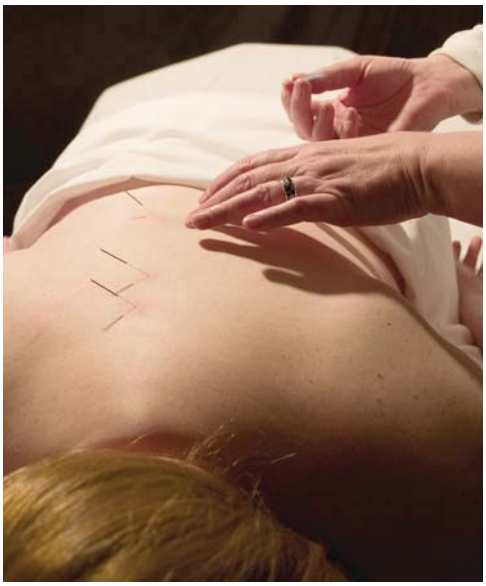
Changes in Amounts and Accounts: I understand that the above installment amount may change upon renewal of my coverage or as a result of other changes I may request be made to my coverage. This authorization is intended to extend to modified installment amounts, which may result from any future coverage renewal submitted by me, and to any other coverage change requested by me. In addition, I may, from time to time, approve updates to the accounts or credit cards to which this Auto Pay Option applies, by contacting your office via phone, email, customer service portal, or by mail. This authorization is intended to apply to any such updates.

Sign Here: _____ **Date:** _____

Scott Danahy Naylon, Co. Inc.

TRUSTED 200 YEARS THE HARTFORD

ACUPUNCTURE



Scott Danahy Naylon, Co., Inc. proudly presents an Insurance Program underwritten with The Hartford, designed specifically for Acupuncture Offices.

The Hartford's small business insurance package, called Spectrum®, has core business coverages that is top of the line. When your business is covered by Spectrum, you'll be covered for a wide range of liability and property risks tailored to businesses like yours. Here are some examples:

- **Property Coverages –** Building and/or contents
- **Liability Limits –** $2 Million/$4Million (Excludes professional/malpractice liability)
- **Equipment Breakdown –** covers the cost to repair or replace equipment
- **Business Income Interruption**
- **Competitive Rates**

Special Optional Coverages

- Valuable Papers
- Backup of Sewers and Drains
- Money and Securities
- Tenants Improvements
- Employee Dishonesty
- Computers and Data

Other Coverages Available

- Workers' Compensation
- Umbrella Liability
- Employment Practice Liability

SDN
SCOTT DANAHY NAYLON
Insurance Brokerage

For More Information or to Obtain a Quote

Inquiries about the program should be directed to the Customer Service Center at **1-877-853-2582, ext. 7702** or visit our web site at: **www.sdnins.com.**