

ALTERNATIVE THERAPIES LIABILITY APPLICATION

If a policy is issued, it will be on a claims made basis. Notice: the policy provides that the limits of liability available to pay judgements or settlements shall be reduced by defense expenses, and that defense expenses shall be applied against the deductible amount.

- Name of Applicant(s): _____
Address: _____
Phone: _____ Fax: _____
- Applicant is: Individual Partnership Corporation Other
- Year Established: _____

Attach copy of applicant's letterhead

- Limits of Liability Desired: _____ Each Claim/Annual Aggregate
- Deductible Desired: \$2500 \$5000 \$25,000 Other
- Please check therapies that you are qualified and will be providing:

- | | | |
|------------------|----------------------------|-----------------------------|
| Acupoint Therapy | Cupping | Myofascial Release Therapy |
| Acupressure | Dietician and Nutritionist | Naturopathic Medicine |
| Acupuncture | Feng Shui | Nutritionists |
| Allergy Testers | Herbal Medicine | Reiki Treatment |
| Aromatherapy | Herbalists | Shiatsu |
| Art Therapy | Homeopathy | Somatic Integration Therapy |
| Astrology | Kinesiology | Speech Therapy |
| Audiologist | Meditation | Tai Chi |
| Breathwork | Music Therapy | Trigger Point Therapy |

Other: _____

- Please provide the following information for all partners, principals, employed professionals and key employees (attach separate sheet if necessary)

Name	Address	SS#	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Is the Applicant engaged in any business or profession other than that described in question 6? Yes No

If yes, please attach an application and estimated revenues

9. Please indicate the total annual gross revenue derived from the services described in question 6 for the past three years and the projected revenues for the current year.

10. For the revenue listed in question 8a, please indicate the approximate percentage derived from each of the services listed in question 6:

Year	Revenue	Service	Percent of Revenue
a) _____	\$ _____	_____	_____ %
b) _____	\$ _____	_____	_____ %
c) _____	\$ _____	_____	_____ %
d) _____	\$ _____	_____	_____ %

11. Is the applicant controlled or owned by or associated or affiliated with, or does it own, any other firm or business enterprise?

Yes No

12. During the past three years, has the Applicant's name been changed, or has the Applicant purchased, merged or consolidated with any other business or has the Applicant been purchased? Yes No If yes, please attach explanation.

13. Are any changes in the nature or size of the Applicant's business anticipated over the next 12 months? Yes No

If yes, please attach an explanation. Changes in size of less than 25% need not be explained.

14. Please indicate the number of (a) Principals, partners, officers and professional employees directly engaged in provided services to clients: _____

(b) All other (non professional/clerical) employees _____

15. Please provide the following:

Names of All Partners, Principals and Key Employees	Professional Qualifications /Designations	# Of Years In Practice	# of Years With Applicant
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

16. Please list professional associations to which Applicant belongs: _____

17. Has the Applicant provided services to any governmental entities? Yes No If yes, please attach an explanation.

18. Has the Applicant provided services to any employee benefits plans, including any pension plans or does plan to do so?

Yes No If yes, please attach an explanation.

19. Has the Applicant provided services to any bank, savings and loan or other financial institution, or does it plan to do so?

Yes No If yes, please attach an explanation.

20. Please indicate the Applicant's five largest jobs/projects during the past three years, showing client's name services provided and gross revenues for each..

Client's Name	Services Provided
Job 1 _____	_____
Job 2 _____	_____
Job 3 _____	_____
Job 4 _____	_____
Job 5 _____	_____

21. Does any director, officer, employee or partner of the Applicant serve on the board of directors of any client of the Applicant?
 Yes No If yes, please attach an explanation.
22. Does the Applicant use a written contract with clients? In all cases Sometimes No
23. Does the Applicant subcontract work to others? Yes No
24. Does the Applicant have a written procedural manual for employees to follow? Yes No
25. Does the Applicant have a formalized training program for newly hired employees? Yes No
26. Has any errors and omissions or professional liability insurance ever been declined or canceled? Yes No
 If yes, please attach an explanation.
27. Is any errors and omissions or professional liability insurance currently in force? Yes No

Provide the following information regarding any coverage during the past five (5) years:

Company	Expiration Date	Limits	Premium
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Retroactive Date of Current Policy: _____

28. Does any director, officer, employee or partner of the applicant have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim? Yes No If yes, please attach an explanation.
29. Has the Applicant or any director, officer, employee or partner of the Applicant ever been the subject of disciplinary action as a result of professional activities? Yes No If yes, please attach an explanation.
30. Please attach a list and status of all errors and omissions claims made during the past three years against the Applicant or any director, officer, employee or partner of the Applicant. If none, please check here None

This insurance application, duly complete, together with any supplementary information, must be signed, in ink, by the Applicant. One signed copy will be attached and form a part of any policy issued. Completion of this insurance application does not bind or obligate the company to offer this insurance. Signing this form, and tendering any payment, does not bind the Company or the applicant to complete the insurance. The insurance application must be signed to be considered for quotation. By signing below you certify that all information you have provided is correct. You herewith authorize the Company or its representatives to gather any additional information they may deem necessary in order to process this application for quotation or to issue a policy. Your signature below authorized, but does not obligate the company to obtain additional information or to verify the information provided from any regulatory agency, provider of services to you or your business, and any financial institution or credit rating company relating to information about you or your business. By your signature, you herewith authorize the release of information regarding your losses, any financial information, or any regulatory compliance matters to the Company. NOTICE: IN NEW YORK, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME. The Applicant hereby acknowledges that the person or entities proposed for insurance are aware that the limits of liability contained in the policy applied for shall be reduced, and may be completely exhausted, by Defense Expenses and, in such event, the Company shall not be responsible for the continued defense of any Claim or liable for Defense Expenses or for the amount of any judgment or settlement to the extent that any of the foregoing exceed the limits of liability of such policy. The applicant hereby further acknowledges that the persons or entities proposed for insurance are aware that Defense Expenses that are incurred shall be applied against the deductible amount.

 Applicant's Signature

 Date