



6250 Claremont Avenue • Oakland, California 94618-1324 • Phone: 510-428-9411 • Toll Free: 800-227-4527 • Fax: 510-654-4634 • www.miec.com

MIEC Acupuncturist Application for Claims-Made Professional Liability Insurance

IMPORTANT NOTICE

You are applying for coverage under MIEC's claims-made policy. If your application is accepted by MIEC, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to MIEC either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

PERSONAL INFORMATION / REQUESTED COVERAGE / LIMITS / MEMBERSHIP

ANSWER 1-4

1. PERSONAL INFORMATION

First Name _____ MI _____ Last Name _____ Male Female

Date of Birth (mm/dd/yyyy) _____ Place of Birth _____ City _____ State _____ Country _____

Social Security Number _____

Home Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Alternate Telephone Number _____

Principal Office Address _____ City _____ State _____ Zip Code _____

Office Telephone Number _____ Office Fax Number _____

E-mail Address _____ Website Address or N/A _____

Preferred Mailing Address Home Office

If you wish to be covered for professional premises liability at your principal office address under Part III of MIEC's policy, please indicate below. There is no additional premium charged for this coverage, but it will be provided only if you request it. Not available for home offices. Yes No

2. REQUESTED COVERAGE EFFECTIVE DATE

Date (mm/dd/yyyy) _____

I request that this insurance commences at 12:01 A.M. on the above date. I understand that all MIEC policies have an annual expiration date of February 1. In light of this, I understand that my initial policy period may be for a term of less than one year, and that my premiums will be pro-rated accordingly.

Coverage and actual effective date are subject to the approval of MIEC's Underwriting Department.

3. REQUESTED LIABILITY LIMITS

Check one: Limit Per Claim / Annual Aggregate: \$500,000/\$1,500,000 \$1,000,000/\$3,000,000

4. MEMBERSHIP INFORMATION

Applicant is a member of _____

Membership in one of your state's specialty associations is recommended – **attach a copy of your membership card.**

TRAINING AND LICENSE INFORMATION

5. TRAINING/CONTINUING EDUCATION

 School Attended City State From To

 Other Training (acupuncture/undergraduate/graduate) City State From To

How many hours of Continuing Education Units have you taken in each of the last two years?
 _____ (last year) _____ (2 years prior)

6. LICENSES

 Acupuncture License Number Effective Date State Is it current? Yes No

 Acupuncture License Number Effective Date State Is it current? Yes No

Professional designation L.Ac. Diplomat of Acupuncture Ph.D.
 MD/DO Doctor of Oriental Medicine Other Explain: _____

PRACTICE INFORMATION

7. TYPE OF PRACTICE

Solo Practice Partnership Corporation – _____
 Employed Acupuncturist - Employer _____

Do you practice under a DBA or fictitious name? Yes No

If yes, DBA name _____

Are you the sole provider under this name? Yes No

Do you advertise your practice? Yes No If yes, please attach a copy including flyers, handouts, etc.

Year you began your practice of acupuncture _____

Describe previous practice (Name of employer, practice) _____
 _____ From To

8. INSURANCE HISTORY

List all professional liability carriers (including current) who have insured you.

Name of Carrier	Policy Number	Expiration Date

Please attach a current Certificate of Insurance to this application.

If policy is claims-made, have you or do you intend to purchase "tail" coverage? Yes No

If your recent coverage was a claims-made policy, you **MUST** either purchase "tail" coverage from your former carrier or apply for "prior acts" coverage. If you purchased tail coverage from your former carrier, send a copy of the endorsement. If you wish to be covered for "prior acts," send a copy of the current policy declarations.

9. PROCEDURES

- a. Do you limit your practice to acupuncture as defined in your state's Business and Professions Code? Yes No

If no, describe: _____

- b. Do you or your employee(s) use disposable needles? Yes No

If no, please confirm that you use non-disposable needles in compliance with the statutes regarding reuse and sterilization of acupuncture needles. Attach a copy of CNT (Clean Needle Technique) certificate.

- c. Do you or your employee(s) perform any procedures involving direct moxibustion?* Yes No

- d. Do you or your employee(s) perform acupuncture as anesthesia for the purpose of performing surgical procedures? Yes No

- e. Do you or your employee(s) perform acupuncture during labor and delivery? Yes No

*These procedures are excluded under the MIEC policy. Any exceptions to these excluded procedures must be submitted to MIEC for approval.

10. CLAIMS

Have you or your employee(s) ever been involved in a malpractice claim, suit or arbitration proceeding, or have you or your employees reported any incidents which resulted in a claim to a former carrier? Yes No

If yes, you must complete a claim information form for each (on page 5).

11. GOVERNMENTAL ACTION

- a. Have you or your employee(s) ever been investigated as the subject of, charged with, or convicted of a misdemeanor or felony? Yes No

- b. Have you or your employee(s) ever entered a "no contest" plea to a crime, other than a traffic violation? Yes No

- c. Have you or your employee(s) ever been investigated by any state or federal regulatory body? Yes No

- d. Has any governmental agency ever suspended, revoked, restricted, placed you/your employee(s) on probation, or taken any other action against your license or your employee's license? Yes No

12. HEALTH

- a. Have you or your employee(s) ever been diagnosed as having or been treated for alcoholism or narcotics addiction? Yes No

- b. Are you or your employee(s) being treated for any medical condition, disease, or illness that affects your ability to provide care or treatment? Yes No

13. INSURANCE

- a. Has any professional liability insurance carrier ever declined, canceled, refused to renew, restricted, or surcharged you or your employee(s)?

Yes No

IF YOU ANSWERED YES TO QUESTIONS 9C -13, PLEASE PROVIDE DETAILS ON YOUR LETTERHEAD or in the Additional Comments section below.

How did you hear about MIEC (check those that apply)

- MIEC Loss Prevention Seminar
 Acupuncture association
 Alumni mailing from Acupuncture College and MIEC
 Colleague referral
 MIEC website
 Annual meeting
 Other: _____
-

ADDITIONAL COMMENTS

SUPPLEMENTARY APPLICATION: PRIOR ACTS "NOSE" COVERAGE

****Complete ONLY if applying for Prior Acts coverage****

1. Prior professional liability coverage was provided by the following claims-made policies and each remained in full force and effect for its entire term:

Company	Policy #	Policy Period From / To	Retroactive Date	Per Claim Limit	Aggregate Limit	Premises Coverage	
						YES	NO

2. **Attach a complete copy of your previous policy or policies, including declarations and all endorsements.**

3. Have you reported any claims, suits or incidents to the companies listed in Question 1? Yes No

If yes, complete a claim information form for each (page 4). Please include acknowledgment that your prior carrier is defending you for all such known claims. *MIEC will not provide any coverage for previously known claims or suits.*

4. Has there been any incident, notification from a patient or patient's attorney, oral or written threat of legal action, subpoena, summons & complaint or any other indication that leads you to believe a malpractice claim or suit will be lodged against you arising from professional services rendered while you were insured with your prior carrier during the period shown under Question 1? Yes No

If yes, provide full details on your letterhead and report all such incidents to your prior carrier immediately.

5. Have you been classified and rated in the same classification for the entire duration of your coverage with your prior carrier? If no, please explain and describe any practice changes during the above policy periods on your letterhead. Yes No

The undersigned represents that the above statements and answers are true and complete, and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

IMPORTANT: *Please send a copy of current policy declarations.*

Signature

Date



APPLICATION FOR CLAIMS-MADE LIABILITY INSURANCE

The undersigned hereby applies to MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned hereby represents that the above statements and answers are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned has been advised that MIEC offers limits of liability at various levels and has voluntarily elected to choose limits on page 1.

The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature

Date

SUBSCRIBER'S AGREEMENT – A LEGAL REQUIREMENT FOR INSURANCE WITH MIEC

For and in consideration of the benefits to be derived therefrom, the subscriber covenants and agrees with MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," and other subscribers thereto through their and each of their Attorney-in-Fact, MEDICAL UNDERWRITERS OF CALIFORNIA, herein called "MUC," to exchange with all other subscribers policies of insurance or reinsurance containing such terms and conditions therein as may be specified by said Attorney-in-Fact and approved by MIEC's Board of Governors or its Executive Committee for any loss insured against, and subscriber hereby designates, constitutes and appoints MUC to be Attorney-in-Fact for subscriber, granting to it power to substitute another in its place and in subscriber's name, place and stead to do all things which the subscriber or subscribers might or could do severally or jointly with reference to the operation and management of MIEC and the business of inter-insurance; subscriber further agrees that from subscriber's premiums there shall be paid to MUC as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MUC.

The remaining portion of the subscriber's premiums shall be applied to the payment of the losses and expenses and to the establishment of reserves and general surplus. Such reserves and surplus may be invested and reinvested by or under the supervision of a Board of Governors duly elected by and from subscribers, which Board or its Executive Committee or an agent or agency appointed by written authority of said Executive Committee shall have full powers to negotiate purchases, sales, trades, exchanges and transfers of investments, properties, titles and securities, together with full powers to execute all necessary instruments. The expenses above referred to shall include all reinsurance, taxes, government charges, allocable claims expense and attorneys' fees and legal expenses and charges, expenses of members and Board of Governors, meetings, and such other specified fees, dues and expenses as may be authorized by the Board of Governors. All other expenses incurred in connection with the conduct of MIEC and such of the above expenses as shall from time to time be agreed upon by and between MUC and the Board of Governors or its Executive Committee shall be borne by MUC.

The principal office of MIEC and its Attorney-in-Fact shall be maintained in the County of Alameda, State of California.

It is intended that by compliance with *Section 1399 and 1400 or 1401 or 1401.5 of the Insurance Code of the State of California* subscribers will have no contingent liability to assessment by reason of membership in the exchange. If because of non-compliance with said code sections a contingent liability arises it shall not be more than an amount equal to and in addition to the amount of the premium deposit provided in the policy or the annual premium earned thereon, whichever is greater.

This instrument can be signed upon any number of counterparts with the same effect as if the signatures of all subscribers were upon and one and the same instrument; shall remain in effect as to all policies or insurance hereafter issued and accepted by subscriber; and shall be binding upon the parties thereto, severally and ratably as provided in policies issued. Wherever the word "subscriber" is used the same shall mean members of MIEC, the subscriber thereto, and all other subscribers to this and any other like agreements.

Signature

Date

Print Name

PRE-PAID MAILING LABEL

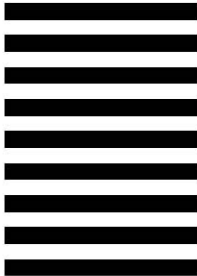
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BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 739 OAKLAND, CA

POSTAGE WILL BE PAID BY ADDRESSEE

Medical Insurance Exchange of California
Attn: UNDERWRITING
6250 Claremont Avenue
Oakland, CA 94618-9983

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES






FIRMLY ATTACH TO YOUR ENVELOPE

.....
(DETACH ALONG DOTTED LINE)

Credit Card Authorization Form
(Annual Payments Only)

Policy number _____



Bill to VISA MASTERCARD AMERICAN EXPRESS

Cardholder name (PLEASE PRINT) _____

Card number _____ Expiration date _____

Card billing address _____

City/State/Zip _____ Daytime phone _____

Signature _____