MIEC
6250 Claremont Avenue
Oakland, CA 94618-1324

800.227.4527 **toll free**
510.654.4634 **fax**

miec.com

MIEC Acupuncturist Application for Claims-Made Professional Liability Insurance

APPLICATION INSTRUCTIONS AND CHECKLIST

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.

INSTRUCTIONS:
Please complete the entire application and indicate not applicable (n/a) where appropriate, then sign and date on pages 8 and 9.

IMPORTANT

PROVIDE THE FOLLOWING ATTACHMENTS WITH APPLICATION *(if applicable)*:

- ☐ Copy of the Declarations page from your current or most recent insurance policy.
- ☐ Extended reporting endorsement (Tail coverage) if purchased from previous carrier.
- ☐ Articles of Incorporation if you wish to add a corporate entity to the policy (see page 3).
- ☐ Samples of your advertising (flyers, handouts, social media posts, etc) (see page 3).
- ☐ Professional Association membership card or payment receipt (see page 4).
- ☐ If you are not using disposable needles, attach a copy of CNT (Clean Needle Technique) certificate (see page 4).

ADDITIONAL COMMENTS:
If you wish to provide detailed responses to any of the questions in the application, please use the "Additional Comments" section on page 5 of the application.

FOR ASSISTANCE:
For assistance, you may call our Acupuncture Account Manager or our Member Services Department at the numbers below from 8:00 a.m. to 5:00 p.m. PST or E-mail us anytime.

MIEC ACUPUNCTURE ACCOUNT MANAGER
Ann Marie Trione
TEL: 510.596.4985
E-MAIL: annmariet@miec.com

MIEC MEMBER SERVICES
TEL: 800.227.4527
FAX: 510.318.6700
E-MAIL: service@miec.com

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

- ☐ MIEC presentation
- ☐ Mailing from MIEC
- ☐ Colleague referral
- ☐ MIEC website
- ☐ Conference
- ☐ Professional association
- ☐ Other: _____

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GENERAL INFORMATION — ANSWER 1

1. CONTACT INFORMATION

First Name _____ MI _____ Last Name _____ ☐ Male ☐ Female ☐ Other

License/Degree (check all that apply): ☐ LAc ☐ DAOM ☐ DTCM ☐ Other: _____ Date of Birth: _____ (mm/dd/yyyy)

Home Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Mobile Phone Number _____

Office Address _____ City _____ State _____ Zip Code _____

Office Phone Number _____ E-mail Address _____

Website Address or ☐ N/A

Preferred Mailing Address ☐ Home ☐ Office

REQUESTED COVERAGE — ANSWER 2-4

2. REQUESTED COVERAGE EFFECTIVE DATE

I request that this insurance commences at 12:01 A.M. on _____ (mm/dd/yyyy)

3. REQUESTED LIABILITY LIMITS

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

4. REQUESTED TAIL OR PRIOR ACTS COVERAGE

Do you currently have an active professional malpractice policy? ☐ Yes ☐ No

If yes, my current malpractice policy is ☐ Claims-Made ☐ Occurrence (Refer to the Declarations page of your current policy)

If Occurrence, skip to the next section.

If Claims-Made, indicate which extended reporting period coverage you intend to purchase:

☐ Tail coverage from my previous carrier.
With this option, I understand that any claims that arise from the prior policy period will be the responsibility of my previous carrier.

☐ Prior Acts / Nose coverage from MIEC. Retroactive date shown on current Claims-Made policy is: _____ (mm/dd/yyyy)
With this option, the retroactive date on your MIEC policy will be the same as the retroactive date on your current policy. Any claims arising from the previous policy can be submitted to MIEC. **You must complete the Prior Acts supplementary application on Page 7.**

☐ I decline to purchase Tail coverage or Prior Acts/Nose coverage.
By declining both, I accept full financial responsibility for any claims that arise from my policy period with my previous insurance carrier. I will not hold MIEC responsible.

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

REQUESTED COVERAGE (continued) — ANSWER 5-6

5. REQUESTED PREMISES LIABILITY

Do you wish to be covered for premises liability (slip and fall) at your principal office address under Part III of MIEC's policy: ☐Yes ☐No

There is no additional premium charge for this coverage, but it will be provided **ONLY** if you request it. Premises liability is recommended for practitioners renting space from a landlord or another practitioner. It is not needed for employees. You can add it now or in the future.

If yes, please provide principal clinic address:

Street Address _____ City _____ State _____ Zip Code _____

6. REQUESTED ADDITIONAL INSURED

Do you wish to add your clinic's landlord as an Additional Insured? ☐Yes ☐No ☐N/A

If yes, please the Landlord/Entity name and address:

Landlord/Entity Name _____

Street Address _____ City _____ State _____ Zip Code _____

There is an additional annual premium charge of $50 for this coverage, and is **ONLY** provided if you request it. You can request to add it now or in the future. Not needed unless your landload requests it. **The effective date for Additional Insured will be the same as the effective date of your policy.**

PRACTICE INFORMATION — ANSWER 7-8

7. TYPE OF PRACTICE

Year you began your practice of acupuncture: _____ (yyyy)

Which best describes your practice situation:

☐Solo Practice ☐Partnership ☐Corporation ☐Employed (name of employer): _____

☐Other: _____

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

8. REQUESTED ENTITY COVERAGE (for corporations only)

Do you wish to add coverage for your corporation? ☐Yes ☐No ☐N/A

If yes, name of entity: _____

There is no additional premium charge to add this coverage. It is **ONLY** provided if you request it. You can request to add it now or in the future.

LICENSE INFORMATION — ANSWER 9

9. LICENSES

Acupuncture License Number _____ Effective Date _____ State _____ Expiration Date _____

Acupuncture License Number _____ Effective Date _____ State _____ Expiration Date _____

NPI Number: _____

Medical License/Certification (check all that apply) ☐LAc ☐NCCAOM Diplomate ☐Other: _____

TRAINING/CONTINUING EDUCATION/MEMBERSHIPS — ANSWER 10-11

10. TRAINING/CONTINUING EDUCATION

School Attended _____ City _____ State _____ From _____ To _____

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

11. MEMBERSHIP INFORMATION

Are you a member of a professional association? ☐Yes ☐No

If yes, which one(s)?

☐ AACMA ☐ AATCM ☐ Acu-Care ☐ CalATMA ☐ CAMA ☐ CA TCM Univ. Alumni Assoc. ☐ CSOMA ☐ CAUA ☐ Han's Medical Group ☐ UAAA ☐ Other: _____

SCOPE OF PRACTICE — ANSWER 12

12. 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.

INSURANCE AND CLAIMS HISTORY — ANSWER 13-15

13. INSURANCE HISTORY ☐None

List all professional liability carriers (including current) who have insured you during the last 5 years. Use Additional Comments (see page 5) or separate sheet of paper, if necessary.

Name of Carrier _____ Coverage Dates: From _____ To _____ Retroactive Date _____

Name of Carrier _____ Coverage Dates: From _____ To _____ Retroactive Date _____

14. INSURANCE DECLINATIONS

Has any professional liability insurance carrier ever declined, canceled, refused to renew, restricted, or surcharged you or your employee(s)? ☐Yes ☐No

15. 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 (see page 6)**.

16. 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

17. 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

IMPORTANT:

IF YOU ANSWERED YES TO QUESTIONS 12c-17, PLEASE PROVIDE DETAILS ON YOUR LETTERHEAD OR IN THE ADDITIONAL COMMENTS SECTION BELOW.

ADDITIONAL COMMENTS

CLAIM INFORMATION FORM

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

MAKE ADDITIONAL COPIES AS NEEDED.

Last Name of Patient/Claimant _____ Gender _____ Age _____

1. Condition and diagnosis of patient prior to treatment:

2. Date(s) and type of treatment rendered by you:

3. Condition of patient subsequent to treatment by you:

4. Nature of allegation:

5. Was a suit ever filed against you? ☐ Yes ☐ No

   If yes, was it served? ☐ Yes ☐ No

   When? _____

6. Names of other practitioners, if any, involved:

7. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

Name of Insurance Carrier Defending You _____ Name of Attorney Defending You _____

SUPPLEMENTARY APPLICATION: PRIOR ACTS "NOSE" COVERAGE

COMPLETE QUESTIONS 1-3 ON THIS SUPPLEMENTARY APPLICATION ONLY IF YOU ARE APPLYING FOR PRIOR ACTS "NOSE" 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

2. 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 6).** 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.

3. 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.**

If no, please explain and describe any practice changes during the above policy periods on your letterhead.

The undersigned represents that all statements and answers in this application 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.

SIGNATURE

Signature _____ Date _____

IMPORTANT

THE FOLLOWING SECTIONS PROVIDE IMPORTANT INFORMATION RELATING TO VARIOUS ASPECTS OF THE INSURANCE YOU ARE APPLYING FOR.

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 all statements and answers in this application 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 acknowledges and agrees that MIEC is relying on the accuracy and completeness of the information provided by the undersigned in making its decision to provide insurance coverage and the terms of that coverage. Incomplete or inaccurate information may be grounds to terminate any coverage extended pursuant to this application.

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 in this application.

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, MIEC UNDERWRITERS, LLC., 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 MIEC UNDERWRITERS, LLC. 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 MIEC UNDERWRITERS, LLC. as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MIEC UNDERWRITERS, LLC.

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 MIEC UNDERWRITERS, LLC. and the Board of Governors or its Executive Committee shall be borne by MIEC UNDERWRITERS, LLC.

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 _____

"CLAIMS-MADE" COVERAGE EXPLANATION

MIEC issues a "claims-made" policy, which insures against claims and suits arising from covered health care services rendered to patients during the time the MIEC policy is in effect, so long as an MIEC policy or a renewal of it is also in effect at the time a claim or suit is first reported to MIEC. If the policy is canceled, not renewed, or terminated for any reason, the insured named in the policy Declaration has a contractual right to purchase Reporting Endorsements ("tail" coverage). If purchased, these Reporting Endorsements will cover claims first made after the date of cancellation, termination or non- renewal provided they arise from covered incidents which occurred while the MIEC policy was in effect.

Under a policy issued by MIEC to an individual doctor, a Reporting Endorsement ("tail" coverage) is provided at no cost in the event of the insured doctor's death or permanent disability. A doctor who has been insured five years or more by MIEC and then retires from private practice at age 55 or more, will also receive "tail" coverage at no additional premium.

First-year claims-made premiums are discounted because only about one-third of claims ultimately attributable to first year incidents will actually be reported to MIEC during the first year. The rest of first year's incidents will be reported as claims during subsequent years. Second, third, fourth and fifth year claims- made premiums increase to reflect this delayed pattern of claims reporting.

Actual premiums charged in future years will vary with inflation, MIEC's claims experience, changes in the legal climate and many other factors that affect professional liability insurance rates. Premiums are based on conservative actuarial recommendations.

Policy provisions which describe the coverage are stated in the policy itself. This explanation does not replace, alter or supersede any of these policy provisions.

AUTHORIZATION TO PROVIDE INFORMATION AND CONSENT TO RELEASE

As an applicant for initial or continued professional liability insurance coverage from MIEC, I consent to the disclosure, inspection and copying of information and documents relating to my credentials and performance ("credentialing information") by and between MIEC and other organizations (e.g. Schools, employers, hospitals, medical staffs, medical groups, independent practice associations (IPA's), health maintenance organizations (HMO's), preferred provider organizations (PPO's) other health delivery systems or entities, medical societies, professional associations, medical schools, training programs, employers, professional liability insurance companies, licensing authorities, or any other person or entity), and individuals acting as their agents for the purpose of evaluating this application for initial or continued professional liability insurance coverage from MIEC..

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I acknowledge and accept such protections and further release all persons and entities providing credentialing information to MIEC from any liability they might incur for their acts and/or communications in connection with the evaluation of my qualifications for professional liability insurance coverage from MIEC.

I authorize and direct any persons or entities in possession of credentialing information or other information related to my qualifications for professional liability insurance coverage from MIEC to cooperate fully with MIEC and its agents and employees in providing such information. MIEC may wish to contact such persons or entities described above both prior to and if issued, after the issuance of a contract of insurance to verify and/or ascertain information regarding credentials, history and background, professional training, experience, character, conduct and judgments, and ability to work with others and I authorize and direct such persons or entities to cooperate fully with MIEC and its agents and employees in responding to such contact.

A photocopy of this application and any addenda thereto, shall be as effective as the original.

Signature	Print Name		Date
Address	City	State	Zip