AMERICAN ACUPUNCTURE COUNCIL

Application *for* Membership

Contact 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 _____

Email _____ Office Phone _____ Cell Phone _____ Fax _____

Practice Background and Declaration

1. Acu License Current? ❒Yes ❒No ❒New Lic. # Pending Lic. #:_____ State:_____ Issued (Mo/Yr): ____/____
2. Acupuncture School:_____ Graduated (Mo/Yr): ____/____
3. Do you hold other healthcare licenses (RN, LMT, DC, etc.)? ❒Yes ❒No If ***Yes***, please list:_____
4. Referrals: When a patient needs care or diagnosis outside your scope, do you refer them to other health providers? ❒Yes ❒No
5. Record Keeping: Do you always carefully document: a) Your patient's comments to you about their condition; b) your observations and conclusions regarding their condition; and c) any treatments you provided or recommended? ❒Yes ❒No
6. Informed Consent: Do you <u>always</u> require your patients to sign an informed consent prior to treatment? ❒Yes ❒No
7. Clean Needle: Do you <u>always</u> follow clean needle technique protocols in your practice? (If ***No***, attach explanation) ❒Yes ❒No
8. Check any of the following techniques you use in your practice:

   ❒ Acupuncture During Labor ❒ Acupuncture to Turn a Breech Baby or Induce Labor ❒ Injection Therapy

   ❒ Techniques Not Taught in Acupuncture Schools (List):_____
9. Do you treat cancer, epilepsy, or acquired immune deficiency syndrome? ❒Yes ❒No If ***Yes***, do you limit your care to complementary care only, provided in coordination with the patient's medical doctor? ❒Yes ❒No (If ***No***, attach explanation)

*(If you answer **Yes** to any of the following, attach a detailed explanation including status, dates, and outcomes.)*

10. Claim History: Has any malpractice claim or allegation ever been asserted against you or your associates? ❒Yes ❒No
11. Potential Claims: Are you aware of any event or indication suggesting a claim may be made against you or that your care might have been deficient or caused harm? ❒Yes ❒No
12. Has any agency or association ever investigated or taken any action against you or your license? ❒Yes ❒No
13. Insurance: Have you ever had malpractice insurance denied, canceled, or accepted on special terms? ❒Yes ❒No
14. Criminal History: Have you been charged with or convicted of violating any law other than a minor traffic offense? ❒Yes ❒No
15. Compromised Care: Have you ever provided care to patients when your ability to perform your professional duties was compromised because of a condition, or your use of an intoxicant, medication, or other drug? ❒Yes ❒No

Declaration: I, the applicant, represent that: 1) I am applying for membership/coverage; 2) I signed/typed my name in the place(s) provided herein; and 3) The responses provided in this application are true, and I have not misstated or suppressed any facts**.** I understand that: 1) If coverage is granted, my policy is issued in reliance upon such responses; 2) Such responses are deemed material; 3) Untrue statements could void my insurance; 4) This declaration shall be the basis of, and form a part of, my policy; 5) There is no guarantee that coverage will be renewed; and 6) The Policy requires that I report, in writing, within 3 days, or as soon as practicable, incidents reasonably likely to involve this insurance, including oral or written patient complaints, threats, or lawsuits.

Sign here: _____ **Date:** _____

©Allied Professionals Insurance Services, Inc. All Rights Reserved, Rev. 4/29/21

AMERICAN ACUPUNCTURE COUNCIL

Application *for* Membership (A3001, Page 2 of 2)

Select Coverage and Payment Options:

1. Indicate desired Limit: ❒$2,000,000/$4,000,000 ❒$1,000,000/$3,000,000 ❒ Other (specify) _____
2. Select ***BOTH***: a. Coverage Type: ❒ Claims Made ❒ Occurrence ***- AND -*** b. Coverage Option: ❒ Elite ❒ Preferred
3. Effective Date: Coverage, if approved, is effective the date the app is received. For a later date, specify date: _____
4. Retroactive Coverage: Retroactive Coverage is not automatic, and there may be an additional charge. To apply for Retroactive Coverage, provide your current Declarations Page and specify a desired Retroactive Date: _____
5. If you practice using a Professional Corp or Partnership, ***which you own***, list below to add it, free of charge, as an Additional Insured:

   _____
6. List below to add any other entity added as an Additional Insured (e.g. your Employer, Landlord, etc.). Cost is 5% per entity:

   _____

   _____
7. Who provides your current malpractice policy? _____ Expires: _____

Payment Detail (Refer to coverage proposal)

1. Installments: ❒ Annual ❒ Quarterly * ❒ 10-Pay *

* Quarterly or 10-Pay requires Auto Pay via Credit Card or ACH.

2. Amount Due

Base Coverage Amount Due ----------

- Option: AcuProperty @ $101.63 (1) ----------
- Option: AcuPremier @ $125 ----------
- Option: Arb Packets @ $25/packet ----------
- Other: _____

Total Amount Due: _____

(1) 10,000 Limit thru Lloyd's of London

Credit Card or ACH (Complete applicable section.)

Credit Card Type: ❒Visa ❒MasterCard ❒American Express

Name on Card: _____

Card #: _____

Expires: _____

ACH Payments from: ❒ Personal Account ❒ Business Account

Account #: _____

Bank Name: _____

Bank Routing #: _____

Bank City: _____

Acknowledgement and Authorization

Claims Made Option: I understand that if I have selected the Claims Made option, my Policy will be limited to claims made against me during the Policy period arising out of the rendering of, or failure to render, professional services subsequent to the retroactive date. I understand that the Claims Made option provides that if the Policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the Policy was in force), unless I purchase Extended Coverage within 30 days after termination.

Authorization: If coverage is granted, I authorize you to: 1) Process payments when due, including any installments, by charging the Credit Card or debiting the Bank Account provided, in compliance with issuer agreements and U.S. law, and agree that this authority will remain in effect until I have canceled it in writing; 2) Request and receive information about me, for any underwriting or claim-related inquiry, from any professional association, licensing board or health care organization; and 3) Communicate with me related to my coverage/membership through Email, Fax, Phone and/ or Text.

Sign here: _____ **Date:** _____

Submit Application: **By Email**: casemanager@bqinsurance.com **By Fax**: **888-549-4955**