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. License Issues: 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, hereby apply for membership/coverage and declare that I signed/typed my name below, that the above statements are true, and that I have not misstated or suppressed any facts. I 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. I understand that if coverage is granted, I shall have the duty to report in writing, as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits. I hereby authorize release of information to the American Acupuncture Council for any underwriting or claim-related inquiry, from any acupuncture professional association, licensing board or health care organization. I understand that there is no guarantee that coverage will be renewed.

Sign here: _____ **Date:** _____

AMERICAN ACUPUNCTURE COUNCIL

Application *for* Membership (A3001.SS, 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. Effective Date: Coverage, if approved, is effective the date the app is received. For a later date, specify date: _____
3. 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: _____
4. If you practice using a Professional Corp or Partnership, ***which you own***, list below to add it, free of charge, as an Additional Insured:

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

   _____

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

Payment Detail (Refer to Quote/Rate Sheet for details)

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

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

2. Amount Due

Total Amount Due _____

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, the applicant, declare that I have signed/typed my name below. I understand that if I have selected the Claims Made option, my policy will be limited to claims made against the insured 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 the insured purchased an Extended Coverage Policy within 30 days after termination.

Authorization: If my membership is approved, you are hereby authorized to process payment as indicated above in accordance with applicable issuer agreements. If paying by installments, I authorize that on each due date, the amount due be automatically charged to my Credit Card or debited to my Bank Account, as applicable. I understand that ACH transfers to my account must comply with the provisions of U.S. law, and that the authority to initiate debit entries as indicated will remain in effect until I have cancelled it in writing. I agree to receive communications related to my membership and coverage through Email, Fax, Phone, and/or Text.

Sign here: _____ **Date:** _____

Submit Application: **By Email**: info@schlittservices.com **By Fax**: 772-778-1416

SUPPLEMENT TO APPLICATION FOR ACUPUNCTURIST'S MALPRACTICE

PRACTITIONER'S NAME:_____

Selection of Coverage Limit:	**ANNUAL**	**QTRLY**	**10-Pay**
_____ $100,000 Occurrence/$300,000 Aggregate	$525	$139	$ 56
_____ $500,000 Occurrence/$500,000 Aggregate	$750	$201	$ 81
_____ $1,000,000 Occurrence/$3,000,000 Aggregate	$870	$234	$ 94
_____ $2,000,000 Occurrence/$4,000,000 Aggregate	$900	$243	$ 97

_____ I wish to have "Entity Coverage" for the partnership or corporation named in question #5 (page 2), and I have included potential charge of the above indicated as additional premium for each additional insured.

FLORIDA FRAUD STATEMENT

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I have selected the above limit and coverage option and have enclosed full payment of the premium payable to "*Schlitt Insurance Services, Inc*.".

I understand that coverage will take effect the next business date after receipt – if the application is completely filled out & acceptable by the underwriter, unless I have requested a later date on the application.

Signed_____ Date_____

RETURN SUPPLEMENT ALONG WITH APPLICATION & TOTAL PREMIUM TO:

SCHLITT INSURANCE SERVICES, INC.

1717 INDIAN RIVER BLVD., #300

VERO BEACH, FL 32960

Questions? 800-736-3448 Extension 113