NCMIC
Insurance Company

Licensed Naturopathic Professional Liability Supplemental Application

If you maintain a current Naturopathic license in addition to your Chiropractic license, and desire coverage for this portion of your practice, please complete the following. All questions must be answered. If you need more space, please attach a separate sheet of paper.

- **Please provide a copy of your state issued Naturopathic license.**
- **Coverage for this endorsement will be effective only upon receipt of your Request for Coverage and approval by NCMIC.**

GENERAL INFORMATION

Name: ______________________________
Last First Middle Initial

Policy Number: ______________________________

Mailing Address: ______________________________
Street

____
City State Zip

Office Phone: ____________ FAX: ____________

Home Phone: ____________ Email Address: ____________

Your email address will never be sold. It will be used to send you important messages.

EDUCATION AND LICENSURE INFORMATION

Name of institution where you received your naturopathic training: ______________________________

____

Designation Received: ____________ Years attended: From ________ To ________

Graduation Date: ____________ Original License Date: ____________

Year you began practicing naturopathic medicine: ______________________________

What percent of your practice is Naturopathic? ______________________________

List all states where you currently practice, license number, date of license expiration and the percent of practice in each:

LICENSE NUMBER	STATE	EXPIRATION DATE	% OF PRACTICE

Please attach a copy of each active license you hold.

If you are a faculty member, please list the Institution(s): ______________________________

____

PRACTICE INFORMATION

Please attach a copy of your plan for emergency situations that may occur in your office and a copy of the referral protocols you have in place if your patient requires hospital admission.

Do you discuss and document informed consent prior to treating all patients? ☐ Yes ☐ No

Do you keep documented records on every visit of all treatments performed on patients, including discussion for follow-up care? ☐ Yes ☐ No

Continued

© 2008 NCMIC NFL3984-082107

NCMIC Insurance Company

Licensed Naturopathic Professional Liability Supplemental Application

PRACTICE INFORMATION - continued

Please check the procedures you perform or participate in and include % of practice.

☐ _____ % Basic Naturopathic Practice (Botanical medicine, Homeopathy, Nutritional Counseling)
☐ _____ % Acupuncture ☐ _____ % Behavioral medicine ☐ _____ % Oral Chelation Therapy
☐ _____ % Experimental Procedures
Please list all details and, if FDA-approved program, please provide protocols: ______________________________

____

☐ _____ % Extravasation
Are you treating your patients or patients who have been referred to you? ______________________________
☐ _____ % IV/IM Vitamin and Mineral Therapy
Please list all symptoms/indications treated: ______________________________
If you mix your own solutions, please provide details: ______________________________

☐ _____ % Laser Treatment Type of laser treatment: ______________________________
Conditions treated: ______________________________ Type of laser: ______________________________
☐ _____ % Micro-electrical Stimulation
Please list conditions treated and device(s) used: ______________________________
☐ _____ % Minor Surgery
Defined as in-office minor surgery including repair of superficial wounds, removal of foreign bodies, cysts and other superficial masses with local anesthesia as needed. Please indicate procedures performed:

____

☐ _____ % Pain Management (e.g., trigger point injection, epidurals, etc.) Please list details:

____

☐ _____ % Physical Therapy ☐ _____ % Psychological Counseling ☐ _____ % Ultrasound
☐ _____ % Weight Control - Means of weight control other than diet or exercise: ______________________________

The following treatment methods will be excluded, but please indicate percentage of practice for each:

☐ _____ % IV Chelation Therapy ☐ _____ % Cosmetic Procedures ☐ _____ % Botox
☐ _____ % Mesotherapy ☐ _____ % NAET technique/treatment ☐ _____ % Needle Biopsy
☐ _____ % Paracentesis ☐ _____ % Obstetrics/Pre-Natal Care ☐ _____ % Thoracentesis
☐ _____ % Trigger Point Injections

PLEASE READ, SIGN AND DATE

X ______________________________ X ______________________________
Signature Date

X ______________________________ X ______________________________
Agent Signature Date

For residents of all states except District of Columbia, ME, WA: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
MAINE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Coverage offered by NCMIC Insurance Company.

RETURN THIS FORM

Mail this form to:	Or fax it to:	Questions? Call toll free
NCMIC Insurance Company P.O. Box 9118 Des Moines, IA 50306	**1-800-996-2642**	**1-800-247-8043**

© 2008 NCMIC NFL3984-082107