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/Cell 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

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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		

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GENERAL INFORMATION

Name: ____
Last First Middle Initial

Policy Number: ____

PLEASE READ, SIGN AND DATE

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that NCMIC Insurance Company (NCMIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

New Hampshire residents: By signing this application, I represent that the statements, information, and answers provided herein are true and accurate. I understand that NCMIC Insurance Company (NCMIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

For residents of all states except ME, WA and District of Columbia: 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.

X ______________________________ X ____________________
Signature Date

X ______________________________ X ____________________
Agent Signature Date

☐ Please email me a copy of my revised declaration page (a copy will automatically be mailed to you).

Email Address: ____

RETURN THIS FORM BY MAIL, FAX OR EMAIL

Mail:	Fax:	Email:	Questions? Call toll free
NCMIC Insurance Company P.O. Box 9118 Des Moines, IA 50306	1-800-996-2642	submissions@ncmic.com	1-800-247-8043

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