Association of Ayurvedic Professionals of North America

Professional Liability Application

1. Name of applicant:

   Business address (attach a schedule of additional locations if needed):

2. Telephone:

3. Date established: mm/dd/yyyy

4. Applicant's practice is a:

   ☐ Solo practitioner (unincorporated)
   ☐ Partnership
   ☐ Solo practitioner (incorporated)
   ☐ Corporation (non-profit)
   ☐ Professional Association
   ☐ Corporation (for-profit)
   ☐ Other (describe):

5. Are you a current member of the Association of Ayurvedic Professionals of North America (AAPNA?)

   Yes ☐ No ☐

6. Please state sources and amounts of total revenue:

	Amount last 12 months	Estimated next 12 months
Lectures/Seminars Fees	$	$
Other Services Fees	$	$
Supplement Sales	$	$
Herbal Compounding Sales	$	$
Other (explain)	$	$
Other (explain)	$	$
TOTAL Gross Revenue:	$	$

7. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐
   If Yes, please attach complete details including a description of the incident(s).

8. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐
   If Yes, please complete a Supplemental Claims Information Form for each claim.

9. How many claims have been made in the last five (5) years?

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10. a. Indicate the number of applicant's staff:

	Employed	Contracted
Acupuncturists		
Aesthetician		
Ayurvedic Wellness Consultant		
Laser Technician		
Massage Therapist		
Medical Assistant		
Medical Doctor (M.D.)		
Naturopathic Physician		
Nurse Practitioner		
Physician Assistant		
Registered Nurse		
Yoga Instructor		
Other (specify)		
Other (specify)		

b. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐
If No, please attach explanation.

c. i. Do you require contracted staff to carry their own Professional Liability Insurance? Yes ☐ No ☐

ii. If Yes, do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

iii. Do you want terms to include coverage for contracted staff? Yes ☐ No ☐

d. Has the applicant or have any of the above employees:
(Attach detailed explanation for any 'Yes' answers)

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

ii. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

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11. Provide the following information for all procedures performed, include proof of training/certification, informed consent forms and client selection protocols:

Procedures	Performed By:	Is training cert attached? Yes/No	Is client selection protocol attached? Yes/No	Is informed consent attached? Yes/No	Number per year?
Acupuncture					
Acne Blue Light Treatments					
Botox Injections					
Chemical peels					
Colon Hydrotherapy					
Cosmetology (hair/nails/facials)					
Dermal fillers: Specify Type					
Hormone Therapy (Specify Type and Method of Delivery)					
Laser Hair Treatments					
Laser Lipolysis / SmartLipo					
Laser Skin Treatments: Specify Type					
Massage Therapy					
Mesotherapy					
Microdermabrasion					
Micropigmentation					
Sclerotherapy					
Tattoo Removal					
Tooth Whitening					
Waxing					
Other: Describe:					
Other: Describe:					
Other: Describe:					
Other: Describe:					
Other: Describe:					

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12. a. List current/prior professional liability insurers for the past 3 years (if none, state none):

Insurer	Dates Covered (From-To) mm/dd/yyyy	Limits of Liability per Claim/Aggregate	Deductible	Premium	Coverage Type: Occurrence or Claims-Made
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	

b. If the current/expiring policy is on a Claims-Made form, what is the retroactive date? mm/dd/yyyy

13. a. List current/prior commercial general liability policy including products and completed operations coverage for the past 3 years (if none, state none):

Insurer	Dates Covered: (From-To) mm/dd/yyyy	Limits of Liability per Claim/Aggregate	Deductible	Premium	Coverage Type: Occurrence or Claims-Made
	-	$ /$	$	$	
	-	$ /$	$	$	
	-	$ /$	$	$	

b. If the current/expiring policy is on a Claims-Made form, what is the retroactive date? mm/dd/yyyy

14. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please attach an explanation.

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It is understood and agreed that with respect to questions 7, 8, and 9, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:		
Signature of person authorized to execute on behalf of the applicant:		Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated.
Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.

PLEASE REMIT APPLICATION TO:

Attention: **Ileana M. Bauza, CIC, CRM, CRIS**
Phone: 305-670-5335
Fax. 305-670-9699
Email: ibauza@insource-inc.com
Address: 9500 S. Dadeland Blvd. 4th Floor, Miami, FL. 33156