

## Filing at a Glance

Company: PACO Assurance Company, Inc.

Product Name: OUM Chiropractor Program

TOI: 11.0 Medical Malpractice - Claims

Made/Occurrence

Sub-TOI: 11.0003 Chiropractic

Filing Type: Form

SERFF Tr Num: PCAG-125220508 State: Arkansas

SERFF Status: Closed

State Tr Num: AR-PC-07-025500

Co Tr Num: AR-894-C

Co Status: Pending

State Status:

Reviewer(s): Betty Montesi, Edith

Roberts, Brittany Yielding

Author: Latasha Knox-Campbell

Date Submitted: 07-18-2007

Disposition Date: 07-26-2007

Disposition Status: Approved

Effective Date Requested (New): 01-01-2008

Effective Date Requested (Renewal): 01-01-2008

Effective Date (New):

Effective Date (Renewal):

## General Information

Project Name: 2008 Form Filing

Project Number:

Reference Organization:

Reference Title:

Filing Status Changed: 07-26-2007

State Status Changed: 07-19-2007

Corresponding Filing Tracking Number:

Filing Description:

EXPLANATORY MEMORANDUM

PACO Assurance Company, Inc.

OUM Chiropractor Program

Amendatory Form Filing State of Arkansas

Status of Filing in Domicile: Pending

Domicile Status Comments:

Reference Number:

Advisory Org. Circular:

Deemer Date:

With this filing we are submitting for your approval revisions to the policy forms used with and previously approved for the OUM Chiropractor Program. A detailed description of each revision and/or new submission appears under the applicable heading below. The requested effective date for these changes is January 1, 2008.

During 2008, the company will be relocating to a new building. In anticipation of the address change, all policy forms included with this filing which include the companys address have been amended to include a variable information field for the address information. A new company address change endorsement form is also included.

At present, the companys chiropractic policies are written through a purchasing group, Medical Professionals Program (MPP). However, as use of the purchasing group doesnt seem to afford any benefits or advantages to either the

policyholders or the company, it is our intent to expire the MPP purchasing group registration and cease using the purchasing group in your state as of January 1, 2008. This will have no effect on the policyholders, but some of the companys policy forms will be revised to remove reference to countersignature by a representative of the purchasing group.

1. Revisions to New Business Application (PG-DC-2000 Ed. 1-07)

The New Business Application is being revised to add policy limits of \$500,000/\$1 million as an option to item 3. This option was inadvertently

omitted from the previous version. The revised form is PG-DC-2000 Ed. 1-08.

2. Revisions to Annual Policy Verification (Renewal Questionnaire) (PG-DC-2010 Ed. 1-07)

The Annual Policy Verification form (a.k.a. Renewal Questionnaire) is being revised as indicated below. The revised form is

PG-DC-2010 Ed. 1-08.

- a. Added policy form, county and retroactive date to policy details on Page 1.
- b. Added name, policy number and state to the bottom of Page 2.
- c. Added request to complete all three items to question 4.
- d. Added blank for Entity Tax ID Number to question 4.a.
- e. Added option to decline coverage for the corporation to question 4.a.
- f. Added Yes or No boxes to question 4.b.
- g. Clarified that information for all active and inactive state licenses is required in question 4.c.
- h. Added 10-payment plan as option to item 8 (with Automatic Payment Withdrawal only).

3. Revisions to Annual Separate Limit Entity Coverage Verification (PG-DC-2010CE Ed. 1-07)

The Annual Separate Limit Entity Coverage Verification (a.k.a. Renewal Questionnaire for Corporate Entities) is being revised to add item 5.,

which identifies the payment plans available. The revised form is PG-DC-2010CE Ed. 1-08.

4. Revision to Locum Tenens Endorsement (OUM-C-1001(m) Ed. 6-05)

This form was revised to remove reference to Individual Coverage A, since that language is not consistent with the underlying policy.

The revised form is OUM-C-1001(m) Ed. 1-08.

5. New Employment Exclusion Endorsement (OUM-C-1001(z) Ed. 1-08)

This form, OUM-C-1001(z) Ed. 1-08, excludes coverage for any claim based upon or arising out of professional services performed by a particular person or at a particular facility. Our intent with this endorsement is to eliminate the duplication of coverage, when coverage exists elsewhere for services performed at the named facility or by the person named in the endorsement, and such exposure is not reflected in our policy premium.

6. New General Purpose/Manuscript Endorsement (OUM-C-1001 Ed. 1-08)

This form, OUM-C-1001 Ed. 1-08, will be used in rare situations to accommodate a policyholders request for coverage under non-typical circumstances. In these situations, we would like to be able to accommodate as many unique situations as possible, and have, therefore, submitted the endorsement in blank.

7. New Endorsement to Remove Coverage for Chiropractic Treatment of Animals (OUM-C-AT-R Ed 1-08)

Your state has previously approved an endorsement for chiropractic treatment of animals. This new form will be used when coverage is to be removed.

8. Revisions to Policy Text (PACO-CM-1000 Ed. 1-07; PACO-OC-1000 Ed. 1-07)

For both the occurrence and claims-made policies, we have clarified the definition of Paraprofessional Employee by adding, A paraprofessional employee does not include any chiropractor, physician or surgeon, when he is acting as such. (Reference Definitions Section, item (h)).

For the claims-made policy (only), the Optional Extension Coverage Section has been revised. The previous version indicated that an insured could report claims that took place on or after the retroactive date and before termination of the policy. Claim as defined in the policy does not include the reporting of professional services incidents that may result in a claim. Clarification has been provided by replacing the second

sentence with, Under the Optional Extension Coverage, an Insured can report claims resulting from professional services that took place on or after the retroactive date and before the termination of the policy, subject to any applicable statute of limitations. (emphasis added).

The revised policy forms are PACO-CM-1000 Ed. 1-08; PACO-OC-1000 Ed. 1-08.

We currently have an Arkansas State Amendatory Endorsement, OUMCAR-1030 Ed. 1-07, approved in your state which amends both versions

of our policy text for compliance with Arkansas statutes. This form was not affected by any of the above changes being proposed in this

filing. It is being attached to the Supporting Documentation Tab for Informational Purposes Only for your review of our policy text.

#### 9. New Company Address Change Endorsement (PG-1032-ADD Ed. 1-08)

In preparation for the companys move to a new office building (within the same state/county), the attached endorsement form is being filed

for use in modifying the companys address on policy documents. This form will be provided to policyholders upon the companys relocation,

which is anticipated to be during 2008 (subject to construction schedules).

#### 10. Replacement of Endorsements

As previously mentioned, the Medical Professionals Program (MPP) purchasing group will no longer be used in your state, beginning in 2008.

The following documents have been revised to remove reference to countersignature by an MPP agent. The new edition date for each is 1-08:

- OUM-C-1001(a) Ed. 6-05 - Amend Named Insured
- OUM-C-1001(b) Ed. 6-05 - Amend Business Address
- OUM-C-1001(d) Ed. 6-05 - Amend Limits of Liability
- OUM-C-1001(e) Ed. 6-05 - Amend Premium to Reflect Semi-Retired Practitioner
- OUM-C-1001(f) Ed. 6-05 - Amend Premium to Reflect Employed Practitioner
- OUM-C-1001(g) Ed. 6-05 - Amend Premium to Reflect Sole Practitioner
- OUM-C-1001(h) Ed. 6-05 - Amend Premium to Reflect Part-Time Practitioner
- OUM-C-1001(i) Ed. 6-05 - Amend Premium to Reflect Risk Management Discount
- OUM-C-1001(j) Ed. 6-05 - Reinstatement

OUM-C-1001(n) Ed. 1-07 - Amend Premium to Add Group Discount  
OUM-C-1001(o) Ed. 1-07 - Amend Premium to Remove Group Discount  
OUM-C-1001(r) Ed. 1-07 - Declarations Endorsement  
OUM-C-1001(w) Ed. 6-05 - Amend Premium to Reflect Full-Time Practitioner  
OUM-C-1015 Ed 1-07 - OEC Endorsement  
OUM-C-CM-1025 Ed. 6-05 - Declarations Page Chiropractic (Claims-Made)  
OUM-C-OC-1025 Ed. 6-05 - Declarations Page Chiropractic (Occurrence)  
OUM-C-1035 Ed. 6-05 - Cancellation Notice Other than Non-Payment  
OUM-C-1037 Ed. 6-05 - Cancellation Notice Non-Payment

## Company and Contact

### Filing Contact Information

Latasha Knox-Campbell, Regulatory Compliance Analyst  
110 WESTWOOD PLACE  
BRENTWOOD, TN 37027  
lcampbell@picagroup.com  
(615) 371-8776 [Phone]  
(615) 370-4803[FAX]

### Filing Company Information

PACO Assurance Company, Inc.  
110 Westwood Place  
Brentwood, TN 37027  
(800) 251-5727 ext. [Phone]  
CoCode: 10222  
Group Code: 3504  
Group Name:  
FEIN Number: 36-3998471  
State of Domicile: Illinois  
Company Type:  
State ID Number:

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: PACO Assurance Company - \$50 per filing.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
PACO Assurance Company, Inc.	\$50.00	07-18-2007	14656932

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	07-26-2007	07-26-2007

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
Annual Policy Form Verification		Latasha Knox-Campbell	07-25-2007	07-25-2007
Annual Separate Limit Entity Coverage Verification	Form	Latasha Knox-Campbell	07-25-2007	07-25-2007
Annual Separate Limit Entity Coverage Verification	Form	Latasha Knox-Campbell	07-20-2007	07-20-2007

## Disposition

Disposition Date: 07-26-2007

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Uniform Transmittal Document-Property & Casualty	Approved	Yes
<b>Supporting Document</b>	AR Amendatory Endorsement	Approved	Yes
<b>Form</b>	New Business Application	Approved	Yes
<b>Form (revised)</b>	Annual Policy Verification	Approved	Yes
<b>Form</b>	Annual Policy Verification	Approved	Yes
<b>Form (revised)</b>	Annual Separate Limit Entity Coverage Verification	Approved	Yes
<b>Form</b>	Annual Separate Limit Entity Coverage Verification	Approved	Yes
<b>Form</b>	Annual Separate Limit Entity Coverage Verification	Approved	Yes
<b>Form</b>	Locum Tenens Endorsement	Approved	Yes
<b>Form</b>	Employment Exclusion Endorsement	Approved	Yes
<b>Form</b>	General Purpose/Manuscript Endorsement	Approved	Yes
<b>Form</b>	Remove Treatment of Animals Endorsement	Approved	Yes
<b>Form</b>	Claims-Made Policy Text	Approved	Yes
<b>Form</b>	Occurrence Policy Text	Approved	Yes
<b>Form</b>	Company Address Change Endorsement	Approved	Yes
<b>Form</b>	Amend Named Insured	Approved	Yes
<b>Form</b>	Amend Business Address	Approved	Yes
<b>Form</b>	Amend Limits of Liability	Approved	Yes
<b>Form</b>	Amend Premium to Reflect Semi-Retired Practitioner	Approved	Yes
<b>Form</b>	Amend Premium to Reflect Employed Practitioner	Approved	Yes
<b>Form</b>	Amend Premium to Reflect Sole Practitioner	Approved	Yes
<b>Form</b>	Amend Premium to Reflect Part-Time Practitioner	Approved	Yes
<b>Form</b>	Amend Premium to Reflect Risk Management Discount	Approved	Yes
<b>Form</b>	Reinstatement	Approved	Yes
<b>Form</b>	Amend Premium to Add Group Discount	Approved	Yes
<b>Form</b>	Amend Premium to Remove Group Discount	Approved	Yes
<b>Form</b>	Declarations Endorsement	Approved	Yes
<b>Form</b>	OEC Endorsement	Approved	Yes
<b>Form</b>	Declarations Page (Claims-Made)	Approved	Yes

Created by SERFF on 07-26-2007 09:56 AM

<b>Form</b>	Declarations Page (Occurrence)	Approved	Yes
<b>Form</b>	Cancellation Notice - Other than Non-Payment	Approved	Yes
<b>Form</b>	Cancellation Notice - Non-Payment	Approved	Yes
<b>Form</b>	Reflect Full-Time Practitioner	Approved	Yes

**Amendment Letter**

Amendment Date:

Submitted Date: 07-25-2007

**Comments:**

Renewal Questionnaires PG-DC-2010 Ed. 1-08 and PG-DC-2010CE Ed. 1-08 had the incorrect down payment for our 5 payment plan. The correct down payment should be 25% instead of 20%. I am attaching the renewal questionnaires with the correct down payment.

**Changed Items:**

**Form Schedule Item Changes:**

Form Name	Form Number	Edition Date	Form Type	Action	Replaced Form #	Previous Filing #	Readability Score	Attachments
Annual Policy Verification	PG-DC-2010	1-08	Form	Replaced	PG-DC-2010 Ed. 1-07		0	PG-DC-2010 Ed. 1-08 (Renewal Verification - Gen).pdf

Form Name	Form Number	Edition Date	Form Type	Action	Replaced Form #	Previous Filing #	Readability Score	Attachments
Annual Separate Limit Entity Coverage Verification	PG-DC-2010CE	1-08	Form	Replaced	PG-DC-2010CE Ed. 1-07		0	PG-DC-2010CE Ed. 1-08 (Renewal Verification - Entity - Gen).pdf

**Amendment Letter**

Amendment Date:

Submitted Date: 07-20-2007

**Comments:**

Form PG-DC-2010CE Ed. 1-08, still had an 1-07 edition date at the bottom of the form. This has been corrected.

**Changed Items:**

**Form Schedule Item Changes:**

<b>Form Name</b>	<b>Form Number</b>	<b>Edition Date</b>	<b>Form Type</b>	<b>Action</b>	<b>Replaced Form #</b>	<b>Previous Filing #</b>	<b>Readability Score</b>	<b>Attachments</b>
Annual Separate Limit Entity Coverage Verification	PG-DC-2010CE	1-08	Form	Replaced	PG-DC-2010CE Ed. 1-07		0	PG-DC-2010CE Ed. 1-08 (Renewal Verification - Entity - Gen).pdf

## Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	New Business Application	PG-DC-2000	1-08	Application/ Replaced Binder/Enrollment	PG-DC-2000 Ed. 1-07	0.00	PG-DC-2000 Ed. 1-08 (New Business Application).pdf
Approved	Annual Policy Verification	PG-DC-2010	1-08	Election/Re Replaced jection/Supplemental Applications	PG-DC-2010 Ed. 1-07	0.00	PG-DC-2010 Ed. 1-08 (Renewal Verification - Gen).pdf
Approved	Annual Policy Verification	PG-DC-2010	1-08	Election/Re Replaced jection/Supplemental Applications	PG-DC-2010 Ed. 1-07	0.00	PG-DC-2010 Ed. 1-08 (Renewal Verification - Gen).pdf
Approved	Annual Separate Limit Entity Coverage Verification	PG-DC-2010CE	1-08	Election/Re Replaced jection/Supplemental Applications	PG-DC-2010CE Ed. 1-07	0.00	PG-DC-2010CE Ed. 1-08 (Renewal Verification - Entity - Gen).pdf
Approved	Annual Separate Limit Entity Coverage Verification	PG-DC-2010CE	1-08	Election/Re Replaced jection/Supplemental Applications	PG-DC-2010CE Ed. 1-07	0.00	PG-DC-2010CE Ed. 1-08 (Renewal Verification - Entity - Gen).pdf
Approved	Annual Separate Limit Entity Coverage Verification	PG-DC-2010CE	1-08	Election/Re Replaced jection/Supplemental Applications	PG-DC-2010CE Ed. 1-07	0.00	PG-DC-2010CE Ed. 1-08 (Renewal Verification - Entity - Gen).pdf
Approved	Locum Tenens Endorsement	OUM-C-1001(m)	1-08	Endorseme Replaced nt/Amendm ent/Condi tions	OUM-C-1001(m) Ed. 6-05	0.00	OUM-C-1001(m) Ed. 1-08 (Locum Tenens).pdf

Approved	Employment Exclusion Endorsement	OUM-C-1001(z)	1-08	Endorsement/Amendment/Conditions	New	0.00	OUM-C-1001_z_ Ed. 1-08 _Employment Exclusion Endorsement_.pdf	
Approved	General Purpose/Manuscript Endorsement	OUM-C-1001	1-08	Endorsement/Amendment/Conditions	New	0.00	OUM-C-1001 Ed. 1-08 _General Purpose Endorsement_.pdf	
Approved	Remove Treatment of Animals Endorsement	OUM-C-AT-R	1-08	Endorsement/Amendment/Conditions	New	0.00	OUM-C-AT-R Ed . 1-08 (Endorsement to Remove Animal Coverage).pdf	
Approved	Claims-Made Policy Text	PACO-CM-1000	1-08	Policy/Coverage Form	Replaced	PACO-CM-1000 Ed. 1-07	0.00	PACO-CM-1000 Ed. 1-08 _Claims-Made Policy Text_.pdf
Approved	Occurrence Policy Text	PACO-OC-1000	1-08	Policy/Coverage Form	Replaced	PACO-OC-1000 Ed. 1-07	0.00	PACO-OC-1000 Ed. 1-08 _Occurrence Policy Text_.pdf
Approved	Company Address Change Endorsement	PG-1032-ADD	1-08	Endorsement/Amendment/Conditions	New	0.00	PG-1032-ADD Ed. 1-08 _Company Address Change Endorsement_.pdf	
Approved	Amend Named Insured	OUM-C-1001(a)	1-08	Endorsement/Amendment/Conditions	Replaced	OUM-C-1001(a) Ed. 6-05	0.00	OUM-C-1001_a_ Ed. 1-08 _no PG_ _Amend

								Named Insured_.pdf
Approved	Amend Business Address	OUM-C-1001(b)	1-08	Endorsement/Amendment/Conditions	Replaced	OUM-C-1001(b) Ed. 6-05	0.00	OUM-C-1001_b_Ed. 1-08_no PG_Amend Business Address_.pdf
Approved	Amend Limits of Liability	OUM-C-1001(d)	1-08	Endorsement/Amendment/Conditions	Replaced	OUM-C-1001(d) Ed. 6-05	0.00	OUM-C-1001_d_Ed. 1-8 (no PG) Amend Limits of Liability.pdf
Approved	Amend Premium to Reflect Semi-Retired Practitioner	OUM-C-1001(e)	1-08	Endorsement/Amendment/Conditions	Replaced	OUM-C-1001(e) Ed. 6-05	0.00	OUM-C-1001_e_Ed. 1-08 (No PG) Semi-Retired Practitioner.pdf
Approved	Amend Premium to Reflect Employed Practitioner	OUM-C-1001(f)	1-08	Endorsement/Amendment/Conditions	Replaced	OUM-C-1001(f) Ed. 6-05	0.00	OUM-C-1001_f_Ed. 1-08_no PG_Employed Practitioner_.pdf
Approved	Amend Premium to Reflect Sole Practitioner	OUM-C-1001(g)	1-08	Endorsement/Amendment/Conditions	Replaced	OUM-C-1001(g) Ed. 6-05	0.00	OUM-C-1001_g_Ed. 1-08_no PG_Sole Practitioner_.pdf
Approved	Amend Premium to Reflect Part-Time Practitioner	OUM-C-1001(h)	1-08	Endorsement/Amendment/Conditions	Replaced	OUM-C-1001(h) Ed. 6-05	0.00	OUM-C-1001_h_Ed. 1-08_no PG_Part-Time Practitioner_.pdf
Approved	Amend Premium to Reflect Risk	OUM-C-1001(i)	1-08	Endorsement/Amendment/Conditions	Replaced	OUM-C-1001(i) Ed. 6-05	0.00	OUM-C-1001_i_Ed.

Management Discount	ent/Conditions	1-08 (No PG) Risk Management Discount.pdf
Approved Reinstatement OUM-C-1001(j)	1-08 Other Replaced OUM-C-1001(j) Ed. 6-05	OUM-C-1001_j_ Ed. 1-08_no PG_ _Reinstatement Notice_.pdf
Approved Amend Premium to Add Group Discount OUM-C-1001(n)	1-08 Endorsement/Amendment/Conditions Replaced OUM-C-1001(n) Ed. 1-07	OUM-C-1001_n_ Ed. 1-08_no PG_ _Add Group Discount_.pdf
Approved Amend Premium to Remove Group Discount OUM-C-1001(o)	1-08 Endorsement/Amendment/Conditions Replaced OUM-C-1001(o) Ed. 1-07	OUM-C-1001_o_ Ed. 1-08_no PG_ _Remove Group Discount_.pdf
Approved Declarations Endorsement OUM-C-1001(r)	1-08 Endorsement/Amendment/Conditions Replaced OUM-C-1001(r) Ed. 1-07	OUM-C-1001_r_ Ed. 1-08 (No PG) Additional Named Insured - Shared Limit.pdf
Approved OEC Endorsement OUM-C-1015	1-08 Endorsement/Amendment/Conditions Replaced OUM-C-1015 Ed. 1-07	OUM-C-1015 Ed. 1-08_no PG_ _OEC Endorsement_.pdf
Approved Declarations Page (Claims-Made) OUM-C-CM-1025	1-08 Declaration Replaced OUM-C-CM-1025 Ed. 6-05	OUM-C-CM-1025 Ed. 1-08_no PG_ _CM Dec

						Page_.pdf
Approved	Declarations Page (Occurrence)	OUM-C- OC-1025	1-08	Declaration Replaced s/Schedule	OUM-C-OC-1025 0.00 Ed. 6-05	OUM-C-OC- 1025 Ed. 1- 08 _no PG_ _OC Dec Page_.pdf
Approved	Cancellation Notice - Other than Non- Payment	OUM-C- 1035	1-08	Canc/NonR Replaced en Notice	OUM-C-1035 Ed. 0.00 6-05	OUM-C- 1035 Ed. 1- 08 _no PG_ _Notice of Cancellation _.pdf
Approved	Cancellation Notice - Non- Payment	OUM-C- 1037	1-08	Canc/NonR Replaced en Notice	OUM-C-1037 Ed. 0.00 6-05	OUM-C- 1037 Ed. 1- 08 _no PG_ _CNPP Cancellation Notice_.pdf
Approved	Reflect Full-Time Practitioner	OUM-C- 1001(w)	1-08	Endorseme Replaced nt/Amendm ent/Condi tions	OUM-C-1001(w) 0.00 Ed. 6-05	OUM-C- 1001(w) Ed. 1-08 (no PG) (Full-Time Practitioner). pdf



# Malpractice Insurance

[Insert Company Address Here]

[Insert Company Phone and Fax Numbers Here]



Company  
 \*PACO  
 \*PICA

## Your Personal Information

Last Name  First Name  Middle   
Office Phone Number  Home Phone Number  Fax   
Social Security Number  Date of Birth  Email   
Practice Name   
Primary Practice Address  City   
State  Zip Code  County   
Mailing Address (if different from Primary Practice Address)  City  State  Zip Code   
Do you practice in more than one location?  Yes  No *If yes, please list other locations. If more space is needed, list on a separate sheet.*  
Additional Practice Address  City   
State  Zip Code  County  % of Patient Count   
Chiropractic License Number(s)  State(s)  Date(s) First Licensed   
 State(s)  Date(s) First Licensed   
Chiropractic College  Graduation Date   
Have you ever previously applied to or been insured with OUM, PICA, or PACO?  Yes  No

## Your Practice

1. You Practice: (select one)  
a.  As an independent contractor with other doctors  
b.  As an employee  
Employer name   
c.  As a sole practitioner-unincorporated  
d.  As a sole practitioner-incorporated  
e.  In a professional corporation in which you have ownership  
**If you selected d or e, please complete the following:**  
Legal entity name   
Tax ID number   
Add this entity to my policy  Yes  No  
**If yes,**  Shared Limits  Separate Limits (additional cost)  
The following information on each owner:  
Name Health Care Insurance Co. Limits of Liability  
Specialty  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
2. Total number of employees and independent contractor health care providers in your office (for example, CAs, massage therapists, X-ray technicians, etc.)   
3. Average number of patients you see per week   
4. Average number of hours you work each week

## Your Claims History

1. Have you ever had a claim against you?  Yes  No  
**If yes, for each claim please provide:**  
a. Copy of the Summons & Complaint (if applicable).  
b. A brief narrative.  
c. Current status of case, whether opened or closed. If open, list reserve amount. If closed, list settlement amount.  
2. Are you aware of an incident that may result in a claim against you?  Yes  No  
**If yes, for each incident please give a narrative of the situation on a separate sheet.**  
3. Have you ever:  
a. had malpractice insurance declined, non-renewed for underwriting reasons, canceled or issued on a restricted basis?  Yes  No  
b. had your chiropractic license subject to probation, revoked or suspended, or had a complaint filed against you?  Yes  No  
c. been convicted of or pleaded no contest to a violation of any law or ordinance other than minor traffic offenses?  Yes  No  
d. had any chronic illness, disability, or drug-or alcohol-related condition that affected your ability to practice chiropractic?  Yes  No





Please mark any changes, additions or deletions in the area on the right, and answer all questions.

**1. Current Personal Information:**

**Name:** Lynne K. Cooke, DC  
**Primary Office:** 110 Westwood Place, Suite 0  
 Brentwood, TN 37027  
**Phone:** (615) 371-8776  
**Fax:** (615) 371-8775  
**Email:** **Please provide**  
**Mailing Address:** 110 Westwood Place, Suite 0  
 Brentwood, TN 37027  
**Billing Address:** 110 Westwood Place, Suite 0  
 Brentwood, TN 37027

**CHANGES TO Current Personal Information:**

**Name:**  
**Primary Office:**  
**Phone:**  
**Fax:**  
**Email:**  
**Mailing Address:**  
**Billing Address:**

**Change Limit of Liability: (select one)**  
 100/300  200/600  250/750  500/1M  
 500/1.5M  1M/1M  1M/3M  Other \_\_\_\_\_

**2. Policy Details:**

**Policy Number:** **06-2CH-0001234**  
**Policy Period:** 1/1/2006 – 1/1/2007  
**Limits of Liability:** \$1,000,000 Per Occurrence/\$3,000,000 Aggregate  
**Policy Form:** Claims Made  
**County:** Williamson  
**Retro Date:** 1/1/1996

**3. Additional Risks:**

- **Legal Entity Coverage:** Primm Springs Chiropractic, P.C.  
**Shared Limit of Liability:** \$1,000,000/\$3,000,000  
**Owners/Shareholders:** Lynne K. Cooke, DC  
 Mark D. Cooke, DC  
 Melissa A. Tiller, DC  
 James Q. Tiller, DC
  
- **Legal Entity Coverage:** Brentwood Chiropractic Care, Inc.  
**Shared Limit of Liability:** \$1,000,000/\$3,000,000  
**Owners/Shareholders:** Lynne K. Cooke, DC

**CHANGES TO Additional Risks:**

**Legal Entity Name:**  
**Remove Coverage?**  Yes  
**Owners/Shareholders:**  
  
**Legal Entity Name:**  
**Remove Coverage?**  Yes  
**Owners/Shareholders:**

\* For legal entities with separate limits of liability, please complete the enclosed Separate Limit Corporation Form.

**4. Practice Details: (Please answer all three questions)**

**(a) Do you have ownership interest in any *additional* Professional Associations (P.A.), Professional Corporations (P.C.) or any other business entity **not listed above**?**

No

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Yes Business entity name:

Owner(s) name(s):

Entity Tax ID Number:

I would like to add a:  Separate Limit of Liability: (Additional Charge)  Shared Limit of Liability: (No Charge)  
 I decline coverage for this corporation

\* If you are requesting coverage for more than one business entity, please mark here  and attach additional entity information on a separate piece of paper.

(b) Do you practice with, associate with or assist another chiropractor or any other physician?  Yes  No

If yes, identify below:

NAME	RELATIONSHIP	INSURED BY

(c) Please list all active and inactive state licenses, and the number of current average patient contact hours under each license.

STATE/COUNTY	LICENSE NUMBER	# OF PATIENT CONTACT HRS PER WEEK

**5. Additional Coverages:**

- Regulatory Defense Coverage – Chiropractor      No Charge/\$0      Limits: \$25,000/\$25,000
- Animal Chiropractic Endorsement      \$500      Limits: \$25,000/\$25,000
- IN Patient Compensation Fund      \$1,046      Limits: \$500,000/\$500,000

**6. Discounts/Surcharges:**

- Employed Practitioner      25% discount
- Part Time Practitioner      25% discount
- New Practitioner – 3<sup>rd</sup> year      35% discount
- Risk Management Home Study      10% discount

**7. Practice Survey:**

In the past twelve months, have you:

- (a) been notified of any claims or incidents?  NO  YES
- (b) had your professional chiropractic license subject to probation, suspended, revoked or had a complaint filed against you?  NO  YES
- (c) been involved in disciplinary proceedings or reprimanded by a governmental agency or professional association?  NO  YES
- (d) been convicted of or pleaded no contest to a violation of any law or ordinance other than a minor traffic offense?  NO  YES
- (e) been treated for alcoholism, drug abuse or chronic illness?  NO  YES
- (f) had privileges at any managed care facility suspended or revoked?  NO  YES

Do you:

- (g) Supply chiropractic professional services to animals?  NO  YES
- (h) Practice obstetrics, gynecological or urological services?  NO  YES

*For any questions answered "yes" for #7 above, please provide a narrative on a separate sheet of paper.*

**8. Payment Plans Available:** Please mark your selection below

- 10 Payment Plan (APW REQUIRED)** – 15% down payment of \$1,000.00 due on 1/1/2006. 9 remaining payments due every month. Includes a finance charge or installment fee.
- 5 Payment Plan** – 25% down payment of \$1,000.00 due on 1/1/2006. 4 remaining payments due every other month. Includes a finance charge or installment fee.
- 2 Payment Plan** – 50% down payment of \$1,500.00 due on 1/1/2006. Remaining payment due in 90 days. No finance charges or installment fees.
- Annual Payment Plan** – Full payment of \$2,000.00 due on 1/1/2006. No finance charge or installment fee.

I have answered these questions to the best of my knowledge. I have not withheld any information that might influence the decision making ability of {CO\_NAME}. My signing of the application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I authorize {COMPANY} to release all pertinent information which may bear upon my insurability to {COMPANY}.

**Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance or statement of claim, containing any materially false information or conceals for the purpose of misleading, information concerning any facts material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution, and confinement in state prison.**

Your Signature \_\_\_\_\_

Date \_\_\_\_\_



**Annual Separate Limit Entity Coverage Verification**  
 Please contact us toll-free at 1-800-423-1504, ext. 7 with any questions

Please mark any changes, additions, or deletions to the below information and answer all questions:

**1. Current Entity Information**

**Name:** Nashville Chiropractic Clinic, P.C.  
**Primary Office:** 12345 Main Street, Nashville, TN 37215  
**Phone:** 615-321-9876 "Please provide" if not on file  
**Fax:** 615-321-8765 "Please provide" if not on file  
**Email:** gsmith@abc.com "Please provide" if not on file  
**Mailing Address:** Not on File  
**Billing Address:** 12345 Main Street, Nashville, TN 37215

**2. Policy Details**

**Policy Number:** 1CP0001235  
**Limits of Liability:** \$1,000,000 Per Occurrence/\$3,000,000 Aggregate

**3. Owners/Shareholders:**

George W. Smith, DPM  
 Janet S. Smith, DPM  
 George W. Smith, Jr., DPM

<b>CHANGES TO Current Entity Information:</b>
<b>Name:</b>
<b>Primary Office:</b>
<b>Phone:</b>
<b>Fax:</b>
<b>Email:</b>
<b>Mailing Address:</b>
<b>Billing Address:</b>
<b>Change Limit of Liability:</b> <input type="checkbox"/> (select one) <input type="checkbox"/> 100/300 <input type="checkbox"/> 200/600 <input type="checkbox"/> 250/750 <input type="checkbox"/> 500/1M <input type="checkbox"/> 500/1.5M <input type="checkbox"/> 1M/1M <input type="checkbox"/> 1M/3M <input type="checkbox"/> Other _____

Have any changes been made to the corporation owners/shareholders in the past twelve months?			
<input type="checkbox"/> NO			
<input type="checkbox"/> YES, identify changes below:			
<b>NAME</b>	<b>RELATIONSHIP</b>	<b>INSURED BY</b>	<b>Check One:</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Add <input type="checkbox"/> Delete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Add <input type="checkbox"/> Delete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Add <input type="checkbox"/> Delete

**4. Practice Survey:**

In the past twelve months, have you:  
 a. been notified of any claims or incidents against the corporation?  NO  YES

**5. Payment Plans Available:**

- Please select the same plan as your individual policy.
- 10 Payment Plan (APW REQUIRED)** – 15% down payment of \$1,000.00 due on 1/1/2006. 9 remaining payments due every month. Includes a finance charge or installment fee.
  - 5 Payment Plan** – 25% down payment of \$1,000.00 due on 1/1/2006. 4 remaining payments due every other month. Includes a finance charge or installment fee.
  - 2 Payment Plan** – 50% down payment of \$1,500.00 due on 1/1/2006. Remaining payment due in 90 days. No finance charges or installment fees.
  - Annual Payment Plan** – Full payment of \$2,000.00 due on 1/1/2006. No finance charge or installment fee.

I have answered these questions to the best of my knowledge. I have not withheld any information that might influence the decision making ability of {CO\_NAME}. My signing of the application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I authorize {COMPANY} to release all pertinent information which may bear upon my insurability to {COMPANY}.

**Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance or statement of claim, containing any materially false information or conceals for the purpose of misleading, information concerning any facts material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution, and confinement in state prison.**

Your Signature \_\_\_\_\_ Date \_\_\_\_\_



**Endorsement No.**

Policy Number	Named Insured	
Policy Inception	Policy Expiration	Effective Date of Endorsement

**It is agreed that this policy is hereby amended as indicated. All other terms and conditions of this policy remain unchanged.**

It is hereby understood and agreed that coverage is being provided to \_\_\_\_\_ while practicing *locum tenens* for the Named Insured during the period beginning \_\_\_\_\_ and ending \_\_\_\_\_ only; and no coverage is being provided after \_\_\_\_\_.

Note: "*Locum tenens*" means "Substitute" or "holding the place of" in Latin.

Signature of Authorized Representative <i>Karen S. King</i>	Pro-rata Additional Premium	Pro-rata Return Premium
Date Prepared		



**Endorsement No.**

Policy Number	Named Insured	
Policy Inception	Policy Expiration	Effective Date of Endorsement

**It is agreed that this policy is hereby amended as indicated. All other terms and conditions of this policy remain unchanged.**

This policy does not apply:

To any claim based upon or arising out of professional services performed <by **Name of person to be Excluded - OR- at Name of Facility/Entity to be Excluded**> due to the fact that coverage is already being provided for that exposure.

Signature of Authorized Representative <i>Karen E. King</i> Date Prepared	Pro-rata Additional Premium	Pro-rata Return Premium
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**Endorsement No.**

Policy Number	Named Insured	
Policy Inception	Policy Expiration	Effective Date of Endorsement

**It is agreed that this policy is hereby amended as indicated. All other terms and conditions of this policy remain unchanged.**

Signature of Authorized Representative <i>Karen E. King</i> Date Prepared	Pro-rata Additional Premium	Pro-rata Return Premium
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**Endorsement No.**

Policy Number	Named Insured	
Policy Inception	Policy Expiration	Effective Date of Endorsement

**It is agreed that this policy is hereby amended as indicated. All other terms and conditions of this policy remain unchanged.**

Effective on the date noted above, the Chiropractic Treatment of Animals Endorsement is hereby removed. The following policy exclusion applies:

- k. To the supplying of **professional services** to animals.

Signature of Authorized Representative <i>Karen S. King</i>	Pro-rata Additional Premium	Pro-rata Return Premium
Date Prepared		

## CHIROPRACTIC POLICY TEXT

### THIS POLICY IS WRITTEN ON A CLAIMS-MADE BASIS

The various terms and conditions set forth in this policy restrict the insurance granted in the INSURING AGREEMENT. Please read the entire policy carefully to determine what coverage is provided.

In this policy, the words “**you**” and “**your**” refer to the **Named Insured** or **Insureds** shown on the Declaration page. The words “**Company**,” “**we**,” “**us**,” and “**our**” refer to PACO Assurance Company, Inc.

The word “**Insured**” means any person or organization qualifying as an **Insured** under THE INSURED section.

The word “**corporation**” includes a partnership, association, or other business entity.

Other words and phrases that appear in **bold** are defined in the DEFINITIONS section.

In consideration of the payment of the premium, in reliance upon the statements in the **application** on file with the **Company** hereto and made a part hereof, and subject to the limits of liability shown in the Declarations, and subject to all the terms of this insurance, the **Company** agrees with the **Insured** as follows:

### INSURING AGREEMENT

**We** agree to pay on behalf of the **Insured** all sums which the **Insured** shall become legally obligated to pay as **damages** as a result of **CLAIMS FIRST MADE AGAINST THE INSURED AND REPORTED TO THE COMPANY IN WRITING DURING THE POLICY PERIOD** because of malpractice committed by the **insured**. The event giving rise to the **claim** must have occurred subsequent to the **retroactive date** specified in the Declarations and before the expiration date of the policy. In no event shall there be indemnity coverage for **claims** against a **corporation** which are based upon the individual acts of any chiropractor, **physician** or surgeon, when he is acting as such.

**It is a condition precedent to coverage under this policy that all claims and suits be reported in compliance with the CLAIM CONDITIONS section of this policy.**

**Defense, Settlement:** With respect to the insurance afforded by this policy, the **Company** shall defend any **claim** or suit against the **Insured** seeking **damages** to which this insurance applies, even if any of the allegations are groundless, false or fraudulent. Subject to the LIMITS OF LIABILITY section, the **Company** may appoint counsel and make such investigation of any **claim** or suit as it deems expedient but the **Company** shall not be obligated to pay any **claim** or judgment or to defend or continue to defend any suit or **claim** after the applicable limit of the **Company's** liability has been exhausted by payment of judgments or settlements.

### THE INSURED

The unqualified word “**Insured**” whenever used in this policy means the following:

- (1) the individual described as the **Named Insured** in the Declarations or the **corporation** listed in the Declarations;
- (2) If the **Named Insured** in the Declarations is a **corporation**, any member, stockholder or partner thereof with respect to acts or omissions of any **paraprofessional** or **non-professional employee**, for whose acts or omissions such member, stockholder or partner, is legally responsible as a member, stockholder or partner of the **corporation**; provided, however, that no member, stockholder or partner shall be considered an **Insured** regarding the liability of anyone acting in the capacity of a chiropractor, **physician** or surgeon.

- (3) the heirs, executors, administrators, assigns and legal representatives of each **Insured** above in the event of his death, incapacity or bankruptcy;
- (4) any **paraprofessional or non-professional employee** of the **Named Insured** or of the chiropractic professional **corporation** designated in the Declarations, while acting within the scope of his employment and while acting under the direction and supervision of a licensed chiropractor; provided, however that a **paraprofessional employee** of the **Named Insured** will not be considered an **Insured** under this policy if the **paraprofessional employee** has other valid and collectible insurance coverage which is applicable to the **paraprofessional employee's** liability in connection with a **malpractice incident**.

## DEFINITIONS

Whenever used in this policy or endorsements forming a part hereof:

- (a) **Application** means original written **application**, any renewal **application**, and any written communication submitted to the **Company** for purposes of changing or endorsing the policy.
- (b) **Claim** means a demand, either oral or in writing, received by the **Insured** for money or services, including, but not limited to the service of suit or institution of arbitration proceedings against the **Insured**.
- (c) **Claim expenses** include the following:
  - (1) all expenses, including attorney's fees, incurred by **us**, all costs taxed against the **Insured** in any suit defended by **us**, and interest on that portion of any judgment against the **Insured** which does not exceed **our** limits of liability and which accrues after the entry of the judgment and before **we** have paid, tendered or deposited **our** share of the judgment in court;
  - (2) premiums on bonds to release attachments for an amount not in excess of **our** limits of liability under this policy, and premiums on appeal bonds required in any suit **we** are defending to prevent execution on the portion of the judgment entered against the **Insured** which does not exceed **our** limits of liability; provided, however, **we** have no obligation to apply for or obtain for the **Insured** such bonds to release attachments or appeal bonds;
  - (3) reasonable expenses, as determined by **us**, which **you** incur at **our** request in assisting **us** in the investigation or defense of any **claim** or suit. Reasonable expenses do not include **your** cost of doing business, employee salaries, office expenses, **your** salary, lost professional fees, daily income or **your** forgiveness of amounts owed to **you** for the cost of care of services rendered.
- (d) **Damages** means sums payable because of a **malpractice incident**. "**Damages**" does not include sums payable for **punitive** or exemplary **damages**, fines or penalties.
- (e) **Injury** means bodily **injury**, sickness, disease or death sustained by any one person.
- (f) **Malpractice incident** means any act, error or omission by the **Insured** in the providing of or failure to provide **professional services**. All such acts, errors, or omissions causally related to the rendering of or failure to render **professional services** to one person shall be considered one **malpractice incident**. A pregnant woman and her unborn child shall be considered one person. Causally related acts, errors and omissions include acts, errors and omissions that have a common cause or form a causal chain of events. A **malpractice incident** shall be deemed to have occurred at the time of the earliest act, error or omission comprising that **malpractice incident**. For purposes of this definition, a continuing course of treatment or repeated exposure to substantially the same general conditions constitutes a single **malpractice incident**.
- (g) **Non-professional employee** means a person employed by **you**, or by the chiropractic professional **corporation**, who performs duties or provides services which may be performed or provided without a license as required under applicable state or federal law.

- (h) **Paraprofessional employee** means a person employed by **you**, or by the chiropractic professional **corporation**, who performs duties or provides services for which a license is required under applicable state or federal law, but which must be performed under the supervision of a chiropractor. A **paraprofessional employee** does not include any chiropractor, physician or surgeon, when he is acting as such.
- (i) **Physician** means a doctor of medicine, osteopathy or podiatry within his respective scope of practice as defined by law.
- (j) **Professional services** mean those services which are within the scope of practice of a chiropractor in the state in which the chiropractor is licensed. **Professional services** do not include any services furnished by the **Insured** as a practitioner of any other healing or treating art.

As regards allegations against a **corporation**, **professional services** shall include actions ancillary to the conduct of the chiropractic practice, such as the hiring of qualified professional or **paraprofessional employees**, the establishment and enforcement of proper policies and procedures, and the maintenance of proper records.

- (k) **Policy period** means the period of time from the inception date to the policy expiration date as set forth in the Declarations or to the date the policy is cancelled, whichever occurs first.
- (l) **Retroactive date** means the date identified as such in the Declarations. The **retroactive date** is either:
  - (1) The effective date of the policy; or
  - (2) A date other than the effective date of the policy upon which the **Company** and the **Named Insured** agree that policy coverage will take effect.

## THE EXCLUSIONS

### This Policy Does Not Apply:

- (a) to any **claim** based upon or arising out of any dishonest, fraudulent, criminal, malicious or knowingly wrongful acts, errors or omissions intentionally committed by or at the direction of the **Insured**;
- (b) to any **claim** based upon or arising out of, in whole or in part, discrimination by the **Insured** on the basis of race, creed, age, sex or national origin;
- (c) to any act committed in violation of any law or ordinance;
- (d) to any act committed while under the influence of intoxicants or narcotics; or to any act involving the abusive use of any drug or substance which affects the **Insured's** ability or professional judgment in rendering chiropractic service;
- (e) to any liability arising out of the **Insured's** activities in his capacity as proprietor, superintendent, executive officer, director, partner or trustee of any hospital, sanitarium, clinic with bed-and-board facilities, laboratory or other business enterprise not named as an **Insured** under this policy;
- (f) to any **claim** based upon or arising out of any liability voluntarily assumed by the **Insured** under any contract or agreement, whether written or oral, but this exclusion shall not apply to a written or oral agreement by the **Insured** to indemnify a medical practitioner who admits a patient of the **Insured** to a hospital for care or treatment at the request of the **Insured**, provided that:
  - (1) the medical practitioner's liability arises from his admission of the patient to the hospital, and

- (2) the indemnity afforded the medical practitioner does not refer to or include the acts, errors or omissions in **professional services** rendered or which should have been rendered by the medical practitioner in connection with the admission of the patient to the hospital.

Also, this exclusion shall not apply to a written or oral agreement regarding services by the **Insured** as a member of a formal accreditation, peer review or similar professional board or committee, subject to the limits outlined in the SUPPLEMENTAL BENEFITS section of this policy;

- (g) to any **claim** based upon or arising out of services performed by the **Insured** as a paid consultant for a third party, when such **claim** is made by said third party;
- (h) to any **claim** which, in whole or in part, arises out of or has its origin in sexual misconduct or sexual molestation or any similar act, whether under the guise of treatment or not; but this exclusion shall not apply to liability of the **Insured** arising out of sexual misconduct or molestation or any similar act by any other person for whose acts or omissions the **Insured** is legally responsible;
- (i) to any **claim** based upon or arising out of, in whole or in part, any act, error or omission of an **Insured** outside the scope of practice of chiropractic **professional services** in the state in which that **Insured** is licensed;
- (j) to any **claim** arising out of the provision of chiropractic **professional services** during any time the **Insured's** license to practice chiropractic has been suspended, revoked, voluntarily surrendered or lapsed;
- (k) to the supplying of **professional services** to animals;
- (l) to the use of X-ray (except for diagnostic purposes);
- (m) to radium;
- (n) to the intentional infliction of **injury**.
- (o) to obstetrics, gynecological or urological services, whether or not within the scope of practice of the **Insured's** state;
- (p) to the use of a pool, whether or not within the scope of practice of the **Insured's** state;
- (q) to treatment of the coccyx, whether or not within the scope of practice of the **Insured's** state;
- (r) to the transmission of any communicable disease;
- (s) to any liability assumed by an **Insured** under any oral or written agreement which guarantees the result of any treatment;
- (t) to surgery, whether or not within the **Insured's** scope of practice;
- (u) to any **malpractice incident** arising out of circumstances known to the **Insured** as likely to result in a **claim**, or which through the exercise of ordinary diligence should have been known to the **Insured** as likely to result in a **claim**, prior to the issuance of this policy;
- (v) to any **malpractice incident** or **claim** which was reported, either verbally or in writing to a previous insurance carrier, self-insurance program, trust or other risk assuming entity;
- (w) to any **malpractice incident** based upon or arising from an act, error or omission in the rendering of or failure to render **professional services** before the **retroactive date** when the **Insured** knew or reasonably should have known a **claim** would result;

- (x) to any liability of any **Insured** for the failure of chiropractic **professional services** to conform with any advertising, oral or written promise, contract or representation;
- (y) to any liability of any **Insured's** offer of payment, assumption of any obligation or incurring of any expense without **our** written approval;
- (z) to any **Insured** entering into any agreement with a patient related to the resolution of a **claim** or dispute arising out of the provision of chiropractic **professional services**, unless such agreement is first submitted to the **Company** and approved in writing;
- (aa) to pollution, contamination or waste disposal;
- (bb) to any **claim** for punitive **damages**, exemplary **damages**, fines or other penalties imposed by law, unless that coverage is required by the state where **you** practice;
- (cc) to the liability of any **Insured** arising out of acts or omissions of any chiropractor or **physician you** employ;
- (dd) to liability of any **Insured** arising out of the provision of **professional services** by any of **your** employed chiropractors or any of **your** employees or agents, whether actual or implied by law, which occur while the employed chiropractor's, employee's or agent's license to practice chiropractic or any other license which is needed to perform the services for which said employee or agent is employed has been suspended, revoked, voluntarily surrendered or lapsed;
- (ee) to any liability of any **Insured** arising out of intentionally falsifying, destroying or obliterating healthcare records or other documents or evidence;
- (ff) despite any other provision of this policy, to any **claim** alleged to be caused by:
  - (1) an **Insured's** breach of fiduciary duty;
  - (2) an **Insured's** actual gain of personal profit, or advantage to which the **Insured** is not legally entitled;
  - (3) remuneration paid to an **Insured** if such payment is held by the courts to be in violation of the law;
  - (4) an **Insured's** alleged or actual involvement in any:
    - (a) Anti-trust law violation; or
    - (b) Agreement or conspiracy to restrain trade;
  - (5) the failure to collect contributions owed to any employee benefit plan or the failure to return any contributions if such amounts are, or could be, chargeable to the employee benefit plan;
  - (6) benefits payable or paid to a participant or beneficiary of an employee benefit plan.

For purposes of this exclusion, fiduciary duty means:

The duty that arises when the business transacted, money or property handled, is not **your** own or for **your** benefit, but for the benefit of another person, to whom **you** stand in a relationship implying and necessitating confidence, trust and good faith, whether or not that duty arises by matter of law, contract or otherwise. This includes duties, which may arise as a fiduciary under the Employee Retirement Income Security Act of 1974 or any of its amendments;

- (gg) to any liability for **damages** imposed by an administrative or regulatory order, ruling or similar decree;
- (hh) to any **claim** based upon or arising out of, in whole or in part, a violation of the Health Insurance Portability and Accountability Act and the privacy or security regulations adopted thereunder, or any similar law or statute;

- (ii) to the liability of any **Insured** for any **claim** under any statute or law regulating unfair trade practices, unfair competition, the use of trade secrets, patent, copyright, trademark, or trade dress infringement, or other similar statutes or laws, or any **claim** made under Title 18, U.S.C. § 1961 through 18 U.S.C. § 1968, otherwise known as the Racketeer Influenced and Corrupt Organizations Act, or Title 15, U.S.C.A.;
- (jj) to any liability of any **Insured** under any worker's compensation, unemployment compensation or disability benefits law or under any similar statute;
- (kk) to any **claim** based upon or arising out of, in whole or in part, a violation of the Americans with Disabilities Act.
- (ll) to any liability of a **corporation** arising out of malpractice committed by any person who is a **Named Insured** under any contract of insurance issued or managed by any company which is a part of the PICA Group or committed by any person acting as a chiropractor, **physician** or surgeon.
- (mm) to any act performed by a CRNA (Certified Registered Nurse Anesthetist).

## TERRITORY

This policy applies to malpractice, which happens anywhere in the world, provided that the original suit against the **Insured** is brought within the United States of America.

## LIMITS OF LIABILITY

1. The limits of the **Company's** liability stated in the Declarations shall apply to the individual chiropractor defined as an **Insured** hereunder and to the **corporation** named in the Declarations for malpractice.

### EACH INCIDENT:

Regardless of the number of **Insureds** under the policy, the number of **Insureds** under the policy against whom **claims** are made, the number of persons for whom the **Insured** is legally responsible, the number of persons or entities making **claims** or bringing suits, the number of **claims** made or suits brought because of **injury**, the number of **policy periods** involved or the number of **injuries** involved, the total limit of liability of the **Company** for all **damages** arising out of one covered incident first made against the **Insured** and reported to the **Company** in writing during the **policy period** shall not exceed the amount stated in the Declarations for "each **claim**." The term "each **claim**" in the context of a malpractice **claim**, shall be interpreted to refer to a **malpractice incident** as defined herein.

Notwithstanding that a **claim** or suit is brought against more than one **Insured** under this policy, the coverage afforded hereunder shall not exceed the limits of liability available to any single **Insured**.

### AGGREGATE:

Regardless of the number of **claims** made or suits brought or the number of persons or organizations making **claims** or bringing suits or the number of **Insureds** under this policy against whom **claims** are made, the total limit of the liability of the **Company** for all **damages** arising out of **claims** first made against the **Insured** and reported to the **Company** in writing during the **policy period** for **malpractice incidents** shall not exceed the aggregate limit of liability set forth in the Declarations.

2. The **Company** shall pay in addition to the applicable limits of liability all reasonable **claim expenses**.

## SUPPLEMENTAL BENEFITS

In addition to the limit of the **Company's** liability shown in the Declarations, the **Company** will also pay:

1. up to \$500.00 per day per **claim** to replace income lost when **your** practice is suspended due to the attendance of the **Named Insured** at a hearing or trial at **our** request, up to a maximum of \$5,000 per **claim** and \$10,000 aggregate;

2. legal fees and **damages** that arise out of the **Named Insured's** chiropractic utilization review services, including the rendering of an opinion on the adequacy, necessity or reasonableness of care furnished by another chiropractor based on the review of the patient's records without a physical examination. The supplementary benefit under this paragraph (2) for legal fees and **damages** is limited to \$25,000 per **claim** and \$50,000 aggregate;
3. legal fees and **damages** that arise out of the **Named Insured's** peer review services, including services as a member of a formal accreditation, standards review or other professional board or committee related only to chiropractic. Peer review means the evaluation of the **professional services** rendered by another chiropractor for the purpose of determining the qualifications and/or the competency of the chiropractor. The supplementary benefit under this paragraph (3) for legal fees and **damages** is limited to \$25,000 per **claim** and \$50,000 aggregate.

The **Named Insured's** consent is not needed to make any payment under the SUPPLEMENTAL BENEFITS section of this policy. Further, this section does not change any other terms or conditions of this policy.

## CLAIM CONDITIONS

1. **Notice of Claim or Suit:** As a condition precedent to his right to the protection afforded by this insurance, the **Insured** shall, as soon as practicable, give to the **Company** written notice of any **claim** made against him.

In the event suit is brought against the **Insured**, the **Insured** shall IMMEDIATELY forward to the **Company** every demand, notice, summons, complaint or other process received by him or by his representatives.

2. **Assistance and Cooperation of the Insured:** The **Insured** shall cooperate with the **Company** and upon the **Company's** request shall submit to examination by a representative of the **Company**, under oath if required, and shall attend hearings, depositions and trial and shall assist in effecting settlement, securing and giving evidence, obtaining the attendances of witnesses and in the conduct of suits, as well as in the giving of a written statement or statements to the **Company's** representatives and meeting with such representatives for the purpose of investigation and/or defense, all without charge to the **Company**. The **Insured** shall further cooperate with the **Company** and do whatever is necessary to secure and effect any rights of indemnity, contribution or apportionment which the **Insured** may have. The **Insured** shall not except at his own cost, make any payment, admit any liability, settle any **claims**, assume any obligation or incur any expense without the written consent of the **Company**.
3. **False or Fraudulent Claims:** If any **Insured** shall commit fraud in proffering any **claim** as regards amount or otherwise, this insurance shall become void as to such **Insured** from the date such fraudulent **claim** is proffered.
4. **Consent to Settle:** The **Company** shall not settle any **claim** without the written consent of the **Insured**. If the **Insured** is a **corporation**, the written consent of an **Insured** who was formerly, but is no longer a member of the business entity will not be required; provided that a duly authorized principal of the business entity gives his written consent on behalf of the **corporation**.

The **Insured** cannot unreasonably withhold consent from the **Company**.

## OTHER CONDITIONS

1. **Application:** By acceptance of this policy, the **Insured** agrees that the statements in the **application** are his representations, that they shall be deemed material, that this policy is issued in reliance upon the truth of such representations and that this policy embodies all agreements existing between himself and the **Company**, or any of its agents, relating to this insurance.
2. **Other Insurance:** The insurance afforded by this policy is excess over any other valid and collectible insurance available to any **Insured**, including any amounts collectible under a self-insured retention or trust or other self-insurance plan. This provision does not apply to insurance specifically written to be in excess of this policy.

- (a) When both this insurance and other insurance apply to the loss on the same basis, whether primary, excess or contingent, the **Company** shall not be liable under this policy for a greater proportion of the loss than that stated in the applicable contribution provisions below:
- (b) Contribution by Equal Shares. If all of such other valid and collectible insurance provides for contribution by equal shares, the **Company** shall not be liable for a greater proportion of such loss than would be payable if each insurer were to contribute an equal share until the share of each insurer would equal the lowest applicable limit of liability under any one policy or the full amount of the loss were paid, and with respect to any amount of loss not so paid, the remaining insurers then were to continue to contribute equal shares of the remaining amount of the loss until each such insurer would have paid its limit in full or the full amount of the loss would be paid.
- (c) Contribution by Limits. If any of such other insurance does not provide for contribution by equal shares, the **Company** shall not be liable for a greater proportion of such loss than the applicable limit of liability under this policy for such loss bears to the total applicable limit of liability of all valid and collectible insurance against such loss.

3. **Changes:** Notice to any agent or knowledge possessed by any agent or other person acting on behalf of the **Company** shall not effect a waiver or a change in any part of this policy or stop the **Company** from asserting any right under the terms of the policy, nor shall the terms of this policy be waived or changed, except by endorsement issued to form a part of this policy.

The **Insured** must notify the **Company** within thirty days of any change in practice, including location, employment, procedures, professional association or other affiliations.

4. **Assignment:** Assignment of interest under this policy shall not bind the **Company** unless its consent is endorsed hereon.
5. **Subrogation:** In the event of any payment under this policy, the **Company** shall be subrogated to all the **Insured's** rights of recovery therefor against any person or organization and the **Insured** shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The **Insured** shall do nothing after the **claim** to prejudice such rights.

The **Company** shall not exercise any such rights against any persons, firms or **corporations** included in the definition of "**Insured.**" Notwithstanding the foregoing, however, the **Company** reserves the right to exercise any rights of subrogation against an **Insured** in respect of any **claim** brought about or contributed to by the dishonest, fraudulent, criminal or malicious act or omission of such **Insured.**

6. **Action Against the Company:** No action shall lie against the **Company** unless as a condition precedent thereto, the **Insured** shall have fully complied with all the terms of this policy, nor until the amount of the **Insured's** obligation to pay shall have been fully and finally determined either by judgment against the **Insured** after actual trial or by written agreement of the **Insured**, the claimant and the **Company.**

Nothing contained in this policy shall give any person or organization any right to join the **Company** as a co-defendant in any action against the **Insured** to determine the **Insured's** liability. Bankruptcy or insolvency of the **Insured** or of the **Insured's** estate shall not relieve the **Company** of any of its obligations hereunder.

7. **Cancellations:** This policy may be cancelled by the **Named Insured** by surrender thereof to the **Company** or to any of its authorized agents or by mailing to the aforementioned written notice stating when thereafter the cancellation shall be effective. If cancelled by the **Insured**, the **Company** shall retain the customary short rate proportion of the premium.

This policy may be cancelled by the **Company** by mailing to the **Named Insured** at the address stated in the Declarations written notice stating when not less than thirty (30) days thereafter such cancellation shall be effective. However, if the **Company** cancels the policy because the **Insured** has failed to pay a premium when due, this policy may be cancelled by the **Company** by mailing a written notice of cancellation to the **Insured** stating when, not less than ten (10) days thereafter, such cancellation shall be effective. The mailing of notice as aforementioned shall be sufficient notice and the effective date of cancellation stated in the notice shall become the end of the **policy period.** Delivery of such written notice by the **Named Insured**, the **Company** or its authorized agent shall be equivalent to mailing. If the **Company** cancels, earned premium shall be computed pro rata, except in the event of cancellation for nonpayment of

premium due. Premium adjustment may be made at the time cancellation is effected or as soon as practicable thereafter. **Your** bankruptcy or insolvency shall not preclude **us** from asserting **our** right to cancel or nonrenew this policy.

8. **Premium:** All premiums for this policy shall be computed in accordance with the **Company's** rules, rates, rating plans, premiums and minimum premiums applicable to the insurance afforded herein.
9. **Inspection and Audit:** The **Company** shall be permitted but not obligated to inspect the **Named Insured's** property and operations at any time. Neither the **Company's** right to make inspections nor the making thereof nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of the **Named Insured** or others, to determine or warrant that such property or operations are safe.

The **Company** may examine and audit the **Named Insured's** books and records at any time during the **policy period** and extensions thereof and within three years after the final termination of this policy, as far as they relate to the subject matter of this insurance.

The **Named Insured** shall maintain records of such information as are necessary for premium computation, and shall send copies of such records to the **Company** at the end of the **policy period** as the **Company** may direct.

10. **Liberalization:** In the event the **Company** adopts any revision that would broaden coverage under this policy without additional premium during the **policy period**, the broadened coverage will immediately apply to this policy.
11. **Conformity with Statutes:** Any terms of this policy which are in conflict with the statutes or regulations of any state or jurisdiction in which the policy is issued are amended to conform to such statutes or regulations.
12. **Service of Suit:** It is agreed that in the event of the failure of the **Company** to pay any amount claimed to be due hereunder, the **Company**, at the request of the **Named Insured**, will submit to the jurisdiction of any court of competent jurisdiction within the United States and will comply with all requirements necessary to give such court jurisdiction and all matters arising hereunder shall be determined in accordance with the law and practice of such court. It is further agreed that service of process in such suit may be made upon the Director of the Division of Insurance, State of Illinois, Springfield, Illinois, 62767, and that in any suit instituted against it upon this contract, the **Company** will abide by the final decision of such court or of any appellate court in the event of an appeal.

Further, pursuant to any statute of any state, territory, or district of the United States which makes provision therefor, and which is applicable to the **Company**, the **Company** hereby designates the Superintendent, Commissioner, or Director of Insurance or other officer specified for that purpose in the statute, or his successor or successors in office, as its true and lawful attorney, upon whom may be served any lawful process in an action, suit or proceeding instituted by or on behalf of the **Named Insured** or any beneficiary hereunder arising out of this contract of insurance.

13. **This policy shall be effective when issued, without regard to delivery.**
14. **Throughout this policy, the pronouns "he," "his" and "him" shall be construed to mean a member of either sex.**

### **OPTIONAL EXTENSION COVERAGE (Tail Coverage)**

In the event of termination of this insurance by reason of non-renewal or cancellation, unless the termination is for non-payment of premium or the **Insured's** non-compliance with the terms and conditions of this policy, the **Named Insured** may purchase, for an additional premium, the Optional Extension Coverage. Under the Optional Extension Coverage, an **Insured** can report **claims** resulting from professional services that took place on or after the **retroactive date** and before the termination of the policy, subject to any applicable statute of limitations. The **Named Insured** must request this coverage in writing within thirty (30) days after the policy terminates. The premium for this coverage will be based on the rules and rating plans in effect at the time of policy termination. Written request for this coverage must include full payment of premium for the Optional Extension Coverage as well as any other premiums due and owing the **Company**. If

a written request and premium payment are not submitted to the **Company** within thirty (30) days of termination of this policy, the **Insured** will not be able to exercise this right at a later date and this offer of Optional Extension Coverage is withdrawn by the **Company**. This coverage cannot be cancelled by the **Company** or by the **Named Insured** after the Optional Extension Coverage is issued and the premium is paid in full.

If, however, this insurance is immediately succeeded by similar **claims** made insurance coverage on which **the retroactive date** is the same as, or earlier than, that shown in the Declarations of this policy, the succeeding insurance shall be deemed to be a renewal hereof, and the **Insured** shall have no right to secure Optional Extension Coverage.

This Optional Extension Coverage shall not be available when any **Insured's** license or right to practice his profession is revoked, suspended or surrendered.

The **Insured** has no express, implied, cumulative or vested right to purchase or obtain Optional Extension Coverage at no additional charge, except as provided in this policy.

The **Company** will provide Optional Extension Coverage to the **Named Insured** or the **Named Insured's** estate at no additional charge if any one of the following circumstances occurs during the period of this policy:

1. The **Named Insured** dies; or
2. The **Named Insured** becomes permanently disabled and is unable or incapable of performing or continuing the practice of the chiropractic profession. Such disability:
  - a. Must be certified as such by a qualified medical practitioner;
  - b. Must have existed continuously for not less than six (6) months;
  - c. Must have rendered the **Named Insured** unable or incapable of performing or continuing to perform the practice of chiropractic; and
  - d. Must be expected to be continuous and permanent.
3. The **Named Insured** retires from chiropractic practice at any age after having completed five consecutive years of coverage with the **Company**.
4. The policy terminates for any reason, if the **Named Insured** has been continuously insured by the **Company** for 10 years; except, however, that an **Insured** whose policy has been cancelled for non-payment of premium or for underwriting reasons will not be eligible to obtain Optional Extension Coverage at no additional charge.

This Optional Extension Coverage is subject to all other terms, conditions, and exclusions of the policy. The Optional Extension Coverage only extends the time period during which a claim may be reported, and does not in any way increase the limits of liability of the policy.

IN WITNESS WHEREOF, the **Company** has caused this policy to be signed by its President and Secretary, but this policy shall not be valid unless countersigned on the Declarations page by a duly authorized representative of the **Company**.



President



Secretary

## NUCLEAR ENERGY LIABILITY EXCLUSION ENDORSEMENT (BROAD FORM)

The endorsement modifies the provisions of this policy.

It is agreed that:

1. This policy does not apply:
  - A. Under any Liability Coverage, to bodily injury or property damage
    - (1) with respect to which an Insured under this policy is also an Insured under a nuclear energy liability policy issued by Nuclear Energy Liability Insurance Association, Mutual Atomic Energy Liability Underwriters or Nuclear Insurance Association of Canada, or would be an Insured under any such policy but for its termination upon exhaustion of its limit of liability; or
    - (2) resulting from the hazardous properties of nuclear material and with respect to which (a) any person or organization is required to maintain financial protection pursuant to the Atomic Energy Act of 1954, or any law amendatory thereof, or (b) the Insured is, or had this policy not been issued would be, entitled to indemnity from the United States of America, or any agency thereof, under the agreement entered into by the United States of America, or any agency thereof, with any person or organization.
  - B. Under any Medical Payments Coverage, or any Supplementary Payment provision relating to first aid, to expenses incurred with respect to bodily injury resulting from the hazardous properties of nuclear material and arising out of the operation of a nuclear facility by any person or organization.
  - C. Under any Liability Coverage, to bodily injury or property damage resulting from the hazardous properties of nuclear material, if:
    - (1) the nuclear material (a) is at any nuclear facility owned by, or operated by or on behalf of, an Insured or (b) has been discharged or dispersed therefrom;
    - (2) the nuclear material is contained in spent fuel or waste at any time possessed, handled, used, processed, stored, transported or disposed of by or on behalf of an Insured; or
    - (3) the bodily injury or property damage arises out of the furnishing by an Insured of services, materials, parts or equipment in connection with the planning, construction, maintenance, operation or use of any nuclear facility, but if such facility is located within the United States of America, its territories or possessions or Canada, this exclusion (3) applies only to property damage to such nuclear facility and any property thereat.
2. As used in this endorsement:

"hazardous properties" include radioactive, toxic or explosive properties;

"nuclear material" means source material, special nuclear material or by-product material;

"source material," "special nuclear material," and "by-product material" have the meanings given them in the Atomic Energy Act of 1954 or in any law amendatory thereof;

"spent fuel" means any fuel element or fuel component, solid or liquid, which has been used or exposed to radiation in a nuclear reactor;

"waste" means any waste material (1) containing by-product material and (2) resulting from the operation by any person or organization of any nuclear facility included within the definition of nuclear facility under paragraph (a) and (b) thereof;

"nuclear facility" means:

  - (a) any nuclear reactor;
  - (b) any equipment or device designed or used for (1) separating the isotopes of uranium or plutonium, (2) processing or utilizing spent fuel, or (3) handling, processing or packaging waste;
  - (c) any equipment or device used for the processing, fabricating or alloying of special nuclear material if any time the total amount of such material in the custody of the Insured at the premises where such equipment or device is located consists of or contains more than 25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235;
  - (d) any structure, basin, excavation, premises or place prepared or used for the storage or disposal of waste,

and includes the site on which any of the foregoing is located, all operations conducted on such site and all premises used for such operations;

"nuclear reactor" means any apparatus designed or used to sustain nuclear fission in a self-supporting chain reaction or to contain a critical mass of fissionable material;

"property damage" includes all forms of radioactive contamination of property.

PACO Assurance Company, Inc.  
[Company Address Inserted Here]

**CHIROPRACTIC POLICY TEXT**  
**THIS POLICY IS WRITTEN ON AN OCCURRENCE BASIS**

The various terms and conditions set forth in this policy restrict the insurance granted in the INSURING AGREEMENT. Please read the entire policy carefully to determine what coverage is provided.

In this policy, the words “**you**” and “**your**” refer to the **Named Insured** or **Insureds** shown on the Declaration page. The words “**Company**,” “**we**,” “**us**,” and “**our**” refer to PACO Assurance Company, Inc.

The word “**Insured**” means any person or organization qualifying as an **Insured** under THE INSURED section.

The word “**corporation**” includes a partnership, association, or other business entity.

Other words and phrases that appear in bold are defined in the DEFINITIONS section.

In consideration of the payment of the premium, in reliance upon the statements in the **application** on file with the **Company** hereto and made a part hereof, and subject to the limits of liability shown in the Declarations, and subject to all the terms of this insurance, the **Company** agrees with the **Insured** as follows:

**INSURING AGREEMENT**

**We** agree to pay on behalf of the **Insured** all sums which the **Insured** shall become legally obligated to pay as **damages** as a result of **CLAIMS REPORTED TO THE COMPANY IN WRITING** because of malpractice committed by the **Insured**. The event giving rise to the **claim** must have occurred during the **policy period**. In no event shall there be indemnity coverage for **claims** against a **corporation** which are based upon the individual acts of any chiropractor, **physician** or surgeon, when he is acting as such.

**It is a condition precedent to coverage under this policy that all claims and suits be reported in compliance with the CLAIM CONDITIONS section of this policy.**

**Defense, Settlement:** With respect to the insurance afforded by this policy, the **Company** shall defend any **claim** or suit against the **Insured** seeking **damages** to which this insurance applies, even if any of the allegations are groundless, false or fraudulent. Subject to the LIMITS OF LIABILITY section, the **Company** may appoint counsel and make such investigation of any **claim** or suit as it deems expedient but the **Company** shall not be obligated to pay any **claim** or judgment or to defend or continue to defend any suit or **claim** after the applicable limit of the **Company's** liability has been exhausted by payment of judgments or settlements.

**THE INSURED**

The unqualified word “**Insured**” whenever used in this policy means the following:

- (1) the individual described as the **Named Insured** in the Declarations or the **corporation** listed in the Declarations;
- (2) If the **Named Insured** in the Declarations is a **corporation**, any member, stockholder or partner thereof with respect to acts or omissions of any **paraprofessional** or **non-professional employee**, for whose acts or omissions such member, stockholder or partner, is legally responsible as a member, stockholder or partner of the **corporation**, provided, however, that no member, stockholder or partner shall be considered an **Insured** regarding the liability of anyone acting in the capacity of a chiropractor, **physician** or surgeon.

- (3) the heirs, executors, administrators, assigns and legal representatives of each **Insured** above in the event of his death, incapacity or bankruptcy;
- (4) any **paraprofessional or non-professional employee** of the **Named Insured** or of the chiropractic professional **corporation** designated in the Declarations, while acting within the scope of his employment and while acting under the direction and supervision of a licensed chiropractor; provided, however that a **paraprofessional employee** of the **Named Insured** will not be considered an **Insured** under this policy if the **paraprofessional employee** has other valid and collectible insurance coverage which is applicable to the **paraprofessional employee's** liability in connection with a **malpractice incident**.

## DEFINITIONS

Whenever used in this policy or endorsements forming a part hereof:

- (a) **Application** means original written **application**, any renewal **application**, and any written communication submitted to the **Company** for purposes of changing or endorsing the policy.
- (b) **Claim** means a demand, either oral or in writing, received by the **Insured** for money or services, including, but not limited to the service of suit or institution of arbitration proceedings against the **Insured**.
- (c) **Claim expenses** include the following:
  - (1) all expenses, including attorney's fees, incurred by **us**, all costs taxed against the **Insured** in any suit defended by **us**, and interest on that portion of any judgment against the **Insured** which does not exceed **our** limits of liability and which accrues after the entry of the judgment and before **we** have paid, tendered or deposited **our** share of the judgment in court;
  - (2) premiums on bonds to release attachments for an amount not in excess of **our** limits of liability under this policy, and premiums on appeal bonds required in any suit **we** are defending to prevent execution on the portion of the judgment entered against the **Insured** which does not exceed **our** limits of liability; provided, however, **we** have no obligation to apply for or obtain for the **Insured** such bonds to release attachments or appeal bonds;
  - (3) reasonable expenses, as determined by **us**, which **you** incur at **our** request in assisting **us** in the investigation or defense of any **claim** or suit. Reasonable expenses do not include **your** cost of doing business, employee salaries, office expenses, **your** salary, lost professional fees, daily income or **your** forgiveness of amounts owed to **you** for the cost of care of services rendered.
- (d) **Damages** means sums payable because of a **malpractice incident**. "**Damages**" does not include sums payable for **punitive** or exemplary **damages**, fines or penalties.
- (e) **Injury** means bodily **injury**, sickness, disease or death sustained by any one person.
- (f) **Malpractice incident** means any act, error or omission by the **Insured** in the providing of or failure to provide **professional services**. All such acts, errors, or omissions causally related to the rendering of or failure to render **professional services** to one person shall be considered one **malpractice incident**. A pregnant woman and her unborn child shall be considered one person. Causally related acts, errors and omissions include acts, errors and omissions that have a common cause or form a causal chain of events. A **malpractice incident** shall be deemed to have occurred at the time of the earliest act, error or omission comprising that **malpractice incident**. For purposes of this definition, a continuing course of treatment or repeated exposure to substantially the same general conditions constitutes a single **malpractice incident**.
- (g) **Non-professional employee** means a person employed by **you**, or by the chiropractic professional **corporation**, who performs duties or provides services which may be performed or provided without a license as required under applicable state or federal law.

- (h) **Paraprofessional employee** means a person employed by **you**, or by the chiropractic professional **corporation**, who performs duties or provides services for which a license is required under applicable state or federal law, but which must be performed under the supervision of a chiropractor. A **paraprofessional employee** does not include any chiropractor, physician or surgeon, when he is acting as such.
- (i) **Physician** means a doctor of medicine, osteopathy or podiatry within his respective scope of practice as defined by law.
- (j) **Professional services** mean those services which are within the scope of practice of a chiropractor in the state in which the chiropractor is licensed. **Professional services** do not include any services furnished by the **Insured** as a practitioner of any other healing or treating art.

As regards allegations against a **corporation**, **professional services** shall include actions ancillary to the conduct of the chiropractic practice, such as the hiring of qualified professional or **paraprofessional employees**, the establishment and enforcement of proper policies and procedures, and the maintenance of proper records.

- (k) **Policy period** means the period of time from the inception date to the policy expiration date as set forth in the Declarations or to the date the policy is cancelled, whichever occurs first.

## THE EXCLUSIONS

### This Policy Does Not Apply:

- (a) to any **claim** based upon or arising out of any dishonest, fraudulent, criminal, malicious or knowingly wrongful acts, errors or omissions intentionally committed by or at the direction of the **Insured**;
- (b) to any **claim** based upon or arising out of, in whole or in part, discrimination by the **Insured** on the basis of race, creed, age, sex or national origin;
- (c) to any act committed in violation of any law or ordinance;
- (d) to any act committed while under the influence of intoxicants or narcotics; or to any act involving the abusive use of any drug or substance which affects the **Insured's** ability or professional judgment in rendering chiropractic service;
- (e) to any liability arising out of the **Insured's** activities in his capacity as proprietor, superintendent, executive officer, director, partner or trustee of any hospital, sanitarium, clinic with bed-and-board facilities, laboratory or other business enterprise not named as an **Insured** under this policy;
- (f) to any **claim** based upon or arising out of any liability voluntarily assumed by the **Insured** under any contract or agreement, whether written or oral, but this exclusion shall not apply to a written or oral agreement by the **Insured** to indemnify a medical practitioner who admits a patient of the **Insured** to a hospital for care or treatment at the request of the **Insured**, provided that:
  - (1) the medical practitioner's liability arises from his admission of the patient to the hospital, and
  - (2) the indemnity afforded the medical practitioner does not refer to or include the acts, errors or omissions in **professional services** rendered or which should have been rendered by the medical practitioner in connection with the admission of the patient to the hospital.

Also, this exclusion shall not apply to a written or oral agreement regarding services by the **Insured** as a member of a formal accreditation, peer review or similar professional board or committee, subject to the limits outlined in the SUPPLEMENTAL BENEFITS section of this policy;

- (g) to any **claim** based upon or arising out of services performed by the **Insured** as a paid consultant for a third party, when such **claim** is made by said third party;
- (h) to any **claim** which, in whole or in part, arises out of or has its origin in sexual misconduct or sexual molestation or any similar act, whether under the guise of treatment or not; but this exclusion shall not apply to liability of the **Insured** arising out of sexual misconduct or molestation or any similar act by any other person for whose acts or omissions the **Insured** is legally responsible;
- (i) to any **claim** based upon or arising out of, in whole or in part, any act, error or omission of an **Insured** outside the scope of practice of chiropractic **professional services** in the state in which that **Insured** is licensed;
- (j) to any **claim** arising out of the provision of chiropractic **professional services** during any time the **Insured's** license to practice chiropractic has been suspended, revoked, voluntarily surrendered or lapsed;
- (k) to the supplying of **professional services** to animals;
- (l) to the use of X-ray (except for diagnostic purposes);
- (m) to radium;
- (n) to the intentional infliction of **injury**.
- (o) to obstetrics, gynecological or urological services, whether or not within the scope of practice of the **Insured's** state;
- (p) to the use of a pool, whether or not within the scope of practice of the **Insured's** state;
- (q) to treatment of the coccyx, whether or not within the scope of practice of the **Insured's** state;
- (r) to the transmission of any communicable disease;
- (s) to any liability assumed by an **Insured** under any oral or written agreement which guarantees the result of any treatment;
- (t) to surgery, whether or not within the **Insured's** scope of practice;
- (u) to any **malpractice incident** arising out of circumstances known to the **Insured** as likely to result in a **claim**, or which through the exercise of ordinary diligence should have been known to the **Insured** as likely to result in a **claim**, prior to the issuance of this policy;
- (v) to any **malpractice incident** or **claim** which was reported, either verbally or in writing to a previous insurance carrier, self-insurance program, trust or other risk assuming entity;
- (w) to any liability of any **Insured** for the failure of chiropractic **professional services** to conform with any advertising, oral or written promise, contract or representation;
- (x) to any liability of any **Insured's** offer of payment, assumption of any obligation or incurring of any expense without **our** written approval;
- (y) to any **Insured** entering into any agreement with a patient related to the resolution of a **claim** or dispute arising out of the provision of chiropractic **professional services**, unless such agreement is first submitted to the **Company** and approved in writing;
- (z) to pollution, contamination or waste disposal;

- (aa) to any **claim** for punitive **damages**, exemplary **damages**, fines or other penalties imposed by law, unless that coverage is required by the state where **you** practice;
- (bb) to the liability of any **Insured** arising out of acts or omissions of any chiropractor or **physician you** employ;
- (cc) to liability of any **Insured** arising out of the provision of **professional services** by any of **your** employed chiropractors or any of **your** employees or agents, whether actual or implied by law, which occur while the employed chiropractor's, employee's or agent's license to practice chiropractic or any other license which is needed to perform the services for which said employee or agent is employed has been suspended, revoked, voluntarily surrendered or lapsed;
- (dd) to any liability of any **Insured** arising out of intentionally falsifying, destroying or obliterating healthcare records or other documents or evidence;
- (ee) despite any other provision of this policy, to any **claim** alleged to be caused by:
  - (1) an **Insured's** breach of fiduciary duty;
  - (2) an **Insured's** actual gain of personal profit, or advantage to which the **Insured** is not legally entitled;
  - (3) remuneration paid to an **Insured** if such payment is held by the courts to be in violation of the law;
  - (4) an **Insured's** alleged or actual involvement in any:
    - (a) Anti-trust law violation; or
    - (b) Agreement or conspiracy to restrain trade;
  - (5) the failure to collect contributions owed to any employee benefit plan or the failure to return any contributions if such amounts are, or could be, chargeable to the employee benefit plan;
  - (6) benefits payable or paid to a participant or beneficiary of an employee benefit plan.

For purposes of this exclusion, fiduciary duty means:

The duty that arises when the business transacted, money or property handled, is not **your** own or for **your** benefit, but for the benefit of another person, to whom **you** stand in a relationship implying and necessitating confidence, trust and good faith, whether or not that duty arises by matter of law, contract or otherwise. This includes duties, which may arise as a fiduciary under the Employee Retirement Income Security Act of 1974 or any of its amendments;

- (ff) to any liability for **damages** imposed by an administrative or regulatory order, ruling or similar decree;
- (gg) to any **claim** based upon or arising out of, in whole or in part, a violation of the Health Insurance Portability and Accountability Act and the privacy or security regulations adopted thereunder, or any similar law or statute;
- (hh) to the liability of any **Insured** for any **claim** under any statute or law regulating unfair trade practices, unfair competition, the use of trade secrets, patent, copyright, trademark, or trade dress infringement, or other similar statutes or laws, or any **claim** made under Title 18, U.S.C. § 1961 through 18 U.S.C. § 1968, otherwise known as the Racketeer Influenced and Corrupt Organizations Act, or Title 15, U.S.C.A.;
- (ii) to any liability of any **Insured** under any worker's compensation, unemployment compensation or disability benefits law or under any similar statute;
- (jj) to any **claim** based upon or arising out of, in whole or in part, a violation of the Americans with Disabilities Act.
- (kk) to any liability of a **corporation** arising out of malpractice committed by any person who is a **Named Insured** under any contract of insurance issued or managed by any company which is a part of the PICA Group or committed by any person acting as a chiropractor, **physician** or surgeon.

(II) to any act performed by a CRNA (Certified Registered Nurse Anesthetist).

## TERRITORY

This policy applies to malpractice, which happens anywhere in the world, provided that the original suit against the **Insured** is brought within the United States of America.

## LIMITS OF LIABILITY

1. The limits of the **Company's** liability stated in the Declarations shall apply to the individual chiropractor defined as an **Insured** hereunder and to the **corporation** named in the Declarations for malpractice.

### EACH INCIDENT:

Regardless of the number of **Insureds** under the policy, the number of **Insureds** under the policy against whom **claims** are made, the number of persons for whom the **Insured** is legally responsible, the number of persons or entities making **claims** or bringing suits, the number of **claims** made or suits brought because of **injury**, the number of **policy periods** involved or the number of **injuries** involved, the total limit of liability of the **Company** for all **damages** arising out of one covered incident committed by the **Insured** during the **policy period** and reported to the **Company** in writing shall not exceed the amount stated in the Declarations for "each **claim**." The term "each **claim**" in the context of a malpractice **claim**, shall be interpreted to refer to a **malpractice incident** as defined herein.

Notwithstanding that a **claim** or suit is brought against more than one **Insured** under this policy, the coverage afforded hereunder shall not exceed the limits of liability available to any single **Insured**.

### AGGREGATE:

Regardless of the number of **claims** made or suits brought or the number of persons or organizations making **claims** or bringing suits or the number of **Insureds** under this policy against whom **claims** are made, the total limit of the liability of the **Company** for all **damages** arising out of **claims** reported to the **Company** in writing for **malpractice incidents** committed by the **Insured** during the **policy period** shall not exceed the aggregate limit of liability set forth in the Declarations.

2. The **Company** shall pay in addition to the applicable limits of liability all reasonable **claim expenses**.

## SUPPLEMENTAL BENEFITS

In addition to the limit of the **Company's** liability shown in the Declarations, the **Company** will also pay:

1. up to \$500.00 per day per **claim** to replace income lost when **your** practice is suspended due to the attendance of the **Named Insured** at a hearing or trial at **our** request, up to a maximum of \$5,000 per **claim** and \$10,000 aggregate;
2. legal fees and **damages** that arise out of the **Named Insured's** chiropractic utilization review services, including the rendering of an opinion on the adequacy, necessity or reasonableness of care furnished by another chiropractor based on the review of the patient's records without a physical examination. The supplementary benefit under this paragraph (2) for legal fees and **damages** is limited to \$25,000 per **claim** and \$50,000 aggregate;
3. legal fees and **damages** that arise out of the **Named Insured's** peer review services, including services as a member of a formal accreditation, standards review or other professional board or committee related only to chiropractic. Peer review means the evaluation of the **professional services** rendered by another chiropractor for the purpose of determining the

qualifications and/or the competency of the chiropractor. The supplementary benefit under this paragraph (3) for legal fees and **damages** is limited to \$25,000 per **claim** and \$50,000 aggregate.

The **Named Insured's** consent is not needed to make any payment under the SUPPLEMENTAL BENEFITS section of this policy. Further, this section does not change any other terms or conditions of this policy.

## CLAIM CONDITIONS

1. **Notice of Claim or Suit:** As a condition precedent to his right to the protection afforded by this insurance, the **Insured** shall, as soon as practicable, give to the **Company** written notice of any **claim** made against him.

In the event suit is brought against the **Insured**, the **Insured** shall IMMEDIATELY forward to the **Company** every demand, notice, summons, complaint or other process received by him or by his representatives.

2. **Assistance and Cooperation of the Insured:** The **Insured** shall cooperate with the **Company** and upon the **Company's** request shall submit to examination by a representative of the **Company**, under oath if required, and shall attend hearings, depositions and trial and shall assist in effecting settlement, securing and giving evidence, obtaining the attendances of witnesses and in the conduct of suits, as well as in the giving of a written statement or statements to the **Company's** representatives and meeting with such representatives for the purpose of investigation and/or defense, all without charge to the **Company**. The **Insured** shall further cooperate with the **Company** and do whatever is necessary to secure and effect any rights of indemnity, contribution or apportionment which the **Insured** may have. The **Insured** shall not except at his own cost, make any payment, admit any liability, settle any **claims**, assume any obligation or incur any expense without the written consent of the **Company**.
3. **False or Fraudulent Claims:** If any **Insured** shall commit fraud in proffering any **claim** as regards amount or otherwise, this insurance shall become void as to such **Insured** from the date such fraudulent **claim** is proffered.
4. **Consent to Settle:** The **Company** shall not settle any **claim** without the written consent of the **Insured**. If the **Insured** is a **corporation**, the written consent of an **Insured** who was formerly, but is no longer a member of the business entity will not be required; provided that a duly authorized principal of the business entity gives his written consent on behalf of the **corporation**.

The **Insured** cannot unreasonably withhold consent from the **Company**.

## OTHER CONDITIONS

1. **Application:** By acceptance of this policy, the **Insured** agrees that the statements in the **application** are his representations, that they shall be deemed material, that this policy is issued in reliance upon the truth of such representations and that this policy embodies all agreements existing between himself and the **Company**, or any of its agents, relating to this insurance.
2. **Other Insurance:** The insurance afforded by this policy is excess over any other valid and collectible insurance available to any **Insured**, including any amounts collectible under a self-insured retention or trust or other self-insurance plan. This provision does not apply to insurance specifically written to be in excess of this policy.
  - (a) When both this insurance and other insurance apply to the loss on the same basis, whether primary, excess or contingent, the **Company** shall not be liable under this policy for a greater proportion of the loss than that stated in the applicable contribution provisions below:
  - (b) Contribution by Equal Shares. If all of such other valid and collectible insurance provides for contribution by equal shares, the **Company** shall not be liable for a greater proportion of such loss than would be payable if each insurer were to contribute an equal share until the share of each insurer would equal the lowest applicable limit of liability under any one policy or the full amount of the loss were paid, and with respect to any amount of loss not so

paid, the remaining insurers then were to continue to contribute equal shares of the remaining amount of the loss until each such insurer would have paid its limit in full or the full amount of the loss would be paid.

(c) **Contribution by Limits.** If any of such other insurance does not provide for contribution by equal shares, the **Company** shall not be liable for a greater proportion of such loss than the applicable limit of liability under this policy for such loss bears to the total applicable limit of liability of all valid and collectible insurance against such loss.

3. **Changes:** Notice to any agent or knowledge possessed by any agent or other person acting on behalf of the **Company** shall not effect a waiver or a change in any part of this policy or stop the **Company** from asserting any right under the terms of the policy, nor shall the terms of this policy be waived or changed, except by endorsement issued to form a part of this policy.

The **Insured** must notify the **Company** within thirty days of any change in practice, including location, employment, procedures, professional association or other affiliations.

4. **Assignment:** Assignment of interest under this policy shall not bind the **Company** unless its consent is endorsed hereon.

5. **Subrogation:** In the event of any payment under this policy, the **Company** shall be subrogated to all the **Insured's** rights of recovery therefor against any person or organization and the **Insured** shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The **Insured** shall do nothing after the **claim** to prejudice such rights.

The **Company** shall not exercise any such rights against any persons, firms or **corporations** included in the definition of "**Insured.**" Notwithstanding the foregoing, however, the **Company** reserves the right to exercise any rights of subrogation against an **Insured** in respect of any **claim** brought about or contributed to by the dishonest, fraudulent, criminal or malicious act or omission of such **Insured.**

6. **Action Against the Company:** No action shall lie against the **Company** unless as a condition precedent thereto, the **Insured** shall have fully complied with all the terms of this policy, nor until the amount of the **Insured's** obligation to pay shall have been fully and finally determined either by judgment against the **Insured** after actual trial or by written agreement of the **Insured**, the claimant and the **Company.**

Nothing contained in this policy shall give any person or organization any right to join the **Company** as a co-defendant in any action against the **Insured** to determine the **Insured's** liability. Bankruptcy or insolvency of the **Insured** or of the **Insured's** estate shall not relieve the **Company** of any of its obligations hereunder.

7. **Cancellations:** This policy may be cancelled by the **Named Insured** by surrender thereof to the **Company** or to any of its authorized agents or by mailing to the aforementioned written notice stating when thereafter the cancellation shall be effective. If cancelled by the **Insured**, the **Company** shall retain the customary short rate proportion of the premium.

This policy may be cancelled by the **Company** by mailing to the **Named Insured** at the address stated in the Declarations written notice stating when not less than thirty (30) days thereafter such cancellation shall be effective. However, if the **Company** cancels the policy because the **Insured** has failed to pay a premium when due, this policy may be cancelled by the **Company** by mailing a written notice of cancellation to the **Insured** stating when, not less than ten (10) days thereafter, such cancellation shall be effective. The mailing of notice as aforementioned shall be sufficient notice and the effective date of cancellation stated in the notice shall become the end of the **policy period.** Delivery of such written notice by the **Named Insured**, the **Company** or its authorized agent shall be equivalent to mailing. If the **Company** cancels, earned premium shall be computed pro rata, except in the event of cancellation for nonpayment of premium due. Premium adjustment may be made at the time cancellation is effected or as soon as practicable thereafter. **Your** bankruptcy or insolvency shall not preclude **us** from asserting **our** right to cancel or nonrenew this policy.

8. **Premium:** All premiums for this policy shall be computed in accordance with the **Company's** rules, rates, rating plans, premiums and minimum premiums applicable to the insurance afforded herein.

9. **Inspection and Audit:** The **Company** shall be permitted but not obligated to inspect the **Named Insured's** property and operations at any time. Neither the **Company's** right to make inspections nor the making thereof nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of the **Named Insured** or others, to determine or warrant that such property or operations are safe.

The **Company** may examine and audit the **Named Insured's** books and records at any time during the **policy period** and extensions thereof and within three years after the final termination of this policy, as far as they relate to the subject matter of this insurance.

The **Named Insured** shall maintain records of such information as are necessary for premium computation, and shall send copies of such records to the **Company** at the end of the **policy period** as the **Company** may direct.

10. **Liberalization:** In the event the **Company** adopts any revision that would broaden coverage under this policy without additional premium during the **policy period**, the broadened coverage will immediately apply to this policy.

11. **Conformity with Statutes:** Any terms of this policy which are in conflict with the statutes or regulations of any state or jurisdiction in which the policy is issued are amended to conform to such statutes or regulations.

12. **Service of Suit:** It is agreed that in the event of the failure of the **Company** to pay any amount claimed to be due hereunder, the **Company**, at the request of the **Named Insured**, will submit to the jurisdiction of any court of competent jurisdiction within the United States and will comply with all requirements necessary to give such court jurisdiction and all matters arising hereunder shall be determined in accordance with the law and practice of such court. It is further agreed that service of process in such suit may be made upon the Director of the Division of Insurance, State of Illinois, Springfield, Illinois, 62767, and that in any suit instituted against it upon this contract, the **Company** will abide by the final decision of such court or of any appellate court in the event of an appeal.

Further, pursuant to any statute of any state, territory, or district of the United States which makes provision therefor, and which is applicable to the **Company**, the **Company** hereby designates the Superintendent, Commissioner, or Director of Insurance or other officer specified for that purpose in the statute, or his successor or successors in office, as its true and lawful attorney, upon whom may be served any lawful process in an action, suit or proceeding instituted by or on behalf of the **Named Insured** or any beneficiary hereunder arising out of this contract of insurance.

13. **This policy shall be effective when issued, without regard to delivery.**

14. **Throughout this policy, the pronouns "he," "his" and "him" shall be construed to mean a member of either sex.**

IN WITNESS WHEREOF, the **Company** has caused this policy to be signed by its President and Secretary, but this policy shall not be valid unless countersigned on the Declarations page by a duly authorized representative of the **Company**.



President



Secretary

## NUCLEAR ENERGY LIABILITY EXCLUSION ENDORSEMENT (BROAD FORM)

The endorsement modifies the provisions of this policy.

It is agreed that:

1. This policy does not apply:
  - A. Under any Liability Coverage, to bodily injury or property damage
    - (1) with respect to which an Insured under this policy is also an Insured under a nuclear energy liability policy issued by Nuclear Energy Liability Insurance Association, Mutual Atomic Energy Liability Underwriters or Nuclear Insurance Association of Canada, or would be an Insured under any such policy but for its termination upon exhaustion of its limit of liability; or
    - (2) resulting from the hazardous properties of nuclear material and with respect to which (a) any person or organization is required to maintain financial protection pursuant to the Atomic Energy Act of 1954, or any law amendatory thereof, or (b) the Insured is, or had this policy not been issued would be, entitled to indemnity from the United States of America, or any agency thereof, under the agreement entered into by the United States of America, or any agency thereof, with any person or organization.
  - B. Under any Medical Payments Coverage, or any Supplementary Payment provision relating to first aid, to expenses incurred with respect to bodily injury resulting from the hazardous properties of nuclear material and arising out of the operation of a nuclear facility by any person or organization.
  - C. Under any Liability Coverage, to bodily injury or property damage resulting from the hazardous properties of nuclear material, if:
    - (1) the nuclear material (a) is at any nuclear facility owned by, or operated by or on behalf of, an Insured or (b) has been discharged or dispersed therefrom;
    - (2) the nuclear material is contained in spent fuel or waste at any time possessed, handled, used, processed, stored, transported or disposed of by or on behalf of an Insured; or
    - (3) the bodily injury or property damage arises out of the furnishing by an Insured of services, materials, parts or equipment in connection with the planning, construction, maintenance, operation or use of any nuclear facility, but if such facility is located within the United States of America, its territories or possessions or Canada, this exclusion (3) applies only to property damage to such nuclear facility and any property thereat.
2. As used in this endorsement:

"hazardous properties" include radioactive, toxic or explosive properties;

"nuclear material" means source material, special nuclear material or by-product material;

"source material," "special nuclear material," and "by-product material" have the meanings given them in the Atomic Energy Act of 1954 or in any law amendatory thereof;

"spent fuel" means any fuel element or fuel component, solid or liquid, which has been used or exposed to radiation in a nuclear reactor;

"waste" means any waste material (1) containing by-product material and (2) resulting from the operation by any person or organization of any nuclear facility included within the definition of nuclear facility under paragraph (a) and (b) thereof;

"nuclear facility" means:

  - (a) any nuclear reactor;
  - (b) any equipment or device designed or used for (1) separating the isotopes of uranium or plutonium, (2) processing or utilizing spent fuel, or (3) handling, processing or packaging waste;
  - (c) any equipment or device used for the processing, fabricating or alloying of special nuclear material if any time the total amount of such material in the custody of the Insured at the premises where such equipment or device is located consists of or contains more than 25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235;
  - (d) any structure, basin, excavation, premises or place prepared or used for the storage or disposal of waste,

and includes the site on which any of the foregoing is located, all operations conducted on such site and all premises used for such operations;

"nuclear reactor" means any apparatus designed or used to sustain nuclear fission in a self-supporting chain reaction or to contain a critical mass of fissionable material;

"property damage" includes all forms of radioactive contamination of property.

[Insert Company Name/Logo Here]

**ENDORSEMENT**

**CHANGE OF COMPANY ADDRESS**

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This endorsement modifies the company address wherever appearing in the attached policy document(s) to be:

[Insert new company address]

No other changes are made by this endorsement.



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: [Company Address Inserted Here]
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### **Chiropractor Professional Liability Policy Endorsement**

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Policy Limits</b>		<b>Each Claim Aggregate</b>
<b>Effective Date of Endorsement</b>		<b>MM/DD/YYYY</b>
<b>Purpose</b>		Amend Named Insured
<b>Premium Change</b>		
<b>Your Agent</b>		

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Authorized Signature



<b>Policy Issued By</b>	<p><b>[Company Name Inserted Here]</b>          (Herein called "We" or "Us")          Mailing Address: [Company Address Inserted Here]</p>
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## Chiropractor Professional Liability Policy Endorsement

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>	
<b>Named Insured</b>	
<b>Business Address</b>	
<b>Policy Period</b>	<p>Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b>          12:01 A.M. Standard time at your address stated above</p>
<b>Policy Limits</b>	<p><b>Each Claim Aggregate</b></p>
<b>Effective Date of Endorsement</b>	<p><b>MM/DD/YYYY</b></p>
<b>Purpose</b>	<p>Amend Business Address</p>
<b>Premium Change</b>	
<b>Your Agent</b>	

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Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: [Company Address Inserted Here]
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## **Chiropractor Professional Liability Policy Endorsement**

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Policy Limits</b>		<b>Each Claim Aggregate</b>
<b>Effective Date of Endorsement</b>		<b>MM/DD/YYYY</b>
<b>Purpose</b>		Amend Limits of Liability
<b>Premium Change</b>		
<b>Your Agent</b>		

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Authorized Signature



<b>Policy Issued By</b>	<p><b>[Company Name Inserted Here]</b>          (Herein called "We" or "Us")          Mailing Address: [Company Address Inserted Here]</p>
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## Chiropractor Professional Liability Policy Endorsement

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>	
<b>Named Insured</b>	
<b>Business Address</b>	
<b>Policy Period</b>	<p>Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b>          12:01 A.M. Standard time at your address stated above</p>
<b>Policy Limits</b>	<p><b>Each Claim Aggregate</b></p>
<b>Effective Date of Endorsement</b>	<p><b>MM/DD/YYYY</b></p>
<b>Purpose</b>	<p>Amend Premium to Reflect Semi-Retired Practitioner</p>
<b>Premium Change</b>	
<b>Your Agent</b>	

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Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: [Company Address Inserted Here]
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## **Chiropractor Professional Liability Policy Endorsement**

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Policy Limits</b>		<b>Each Claim Aggregate</b>
<b>Effective Date of Endorsement</b>		<b>MM/DD/YYYY</b>
<b>Purpose</b>		Amend Premium to Reflect Employed Practitioner
<b>Premium Change</b>		
<b>Your Agent</b>		

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Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: [Company Address Inserted Here]
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## **Chiropractor Professional Liability Policy Endorsement**

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Policy Limits</b>		<b>Each Claim Aggregate</b>
<b>Effective Date of Endorsement</b>		<b>MM/DD/YYYY</b>
<b>Purpose</b>		Amend Premium to Reflect Sole Practitioner
<b>Premium Change</b>		
<b>Your Agent</b>		

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Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: [Company Address Inserted Here]
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## **Chiropractor Professional Liability Policy Endorsement**

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Policy Limits</b>		<b>Each Claim Aggregate</b>
<b>Effective Date of Endorsement</b>		<b>MM/DD/YYYY</b>
<b>Purpose</b>		Amend Premium to Reflect Part-Time Practitioner
<b>Premium Change</b>		
<b>Your Agent</b>		

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Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: [Company Address Inserted Here]
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## **Chiropractor Professional Liability Policy Endorsement**

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Policy Limits</b>		<b>Each Claim Aggregate</b>
<b>Effective Date of Endorsement</b>		<b>MM/DD/YYYY</b>
<b>Purpose</b>		Amend Premium to Reflect Risk Management Discount
<b>Premium Change</b>		
<b>Your Agent</b>		

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Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: [Company Address Inserted Here]
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### **Chiropractor Professional Liability Policy Reinstatement Endorsement**

You are hereby notified that the policy designated below, including all attachments and endorsements, is reinstated as stated below in accordance with the terms and conditions of the policy.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. standard at your address stated above
<b>Effective Date of Reinstatement</b>		<b>MM/DD/YYYY</b> at 12:01 A.M. standard time at your address stated above.
<b>Premium</b>		
<b>Your Agent</b>		

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Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: <b>[Company Address Inserted Here]</b>
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## **Chiropractor Professional Liability Policy Endorsement**

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Policy Limits</b>		<b>Each Claim Aggregate</b>
<b>Effective Date of Endorsement</b>		<b>MM/DD/YYYY</b>
<b>Purpose</b>		Amend Premium to Reflect Group Discount
<b>Premium Change</b>		
<b>Your Agent</b>		

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Authorized Signature



<b>Policy Issued By</b>	<p><b>[Company Name Inserted Here]</b>          (Herein called "We" or "Us")          Mailing Address: <b>[Company Address Inserted Here]</b></p>
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## Chiropractor Professional Liability Policy Endorsement

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>	
<b>Named Insured</b>	
<b>Business Address</b>	
<b>Policy Period</b>	<p>Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b>          12:01 A.M. Standard time at your address stated above</p>
<b>Policy Limits</b>	<p><b>Each Claim Aggregate</b></p>
<b>Effective Date of Endorsement</b>	<p><b>MM/DD/YYYY</b></p>
<b>Purpose</b>	<p>Amend Premium to Remove Group Discount</p>
<b>Premium Change</b>	
<b>Your Agent</b>	

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Authorized Signature





<b>Policy Issued By</b>	<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: <b>[Company Address Inserted Here]</b>
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## Chiropractor Professional Liability Policy Optional Extension Coverage Endorsement

In consideration of the payment of the additional premium stated below, and in accordance with the terms and conditions of this policy, this policy is extended to apply to CLAIMS MADE AGAINST THE INSURED AND REPORTED TO THE COMPANY IN WRITING on or after the effective date of this endorsement, subject to any applicable statute of limitations.

This endorsement covers claims that would have been covered under your policy, had they been reported before the date your policy ended. The professional services on which the claim is based must have taken place after the retroactive date of your policy and before the date your policy ended. The claim must first be made during the period of this endorsement.

<b>Policy Number</b>	
<b>Named Insured</b>	
<b>Business Address</b>	
<b>Effective Date of Cancellation</b>	<b>MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Effective Date of This Endorsement</b>	<b>MM/DD/YYYY</b>
<b>Retroactive Date</b>	This insurance does not apply to Professional Services which take place Before the Retroactive Date shown below. <b>Retroactive Date: MM/DD/YYYY</b>
<b>Premium due for this Endorsement</b>	<b>\$X,XXX.XX</b>
<b>Your Agent</b>	

---

Authorized Signature



<b>Policy Issued By</b>	<p><b>[Company Name Inserted Here]</b>          (Herein called "We" or "Us")          Mailing Address: <b>[Company Address Inserted Here]</b>          In the event of questions, please call <b>[Toll-Free Number Inserted Here]</b></p>
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## Chiropractor Professional Liability Policy Declarations Page

**Claims Made Policy:** Except to such extent as may be provided otherwise herein, this policy is limited to liability only for those CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. **Please review the policy carefully.**

<b>Policy Number</b>	
<b>Named Insured</b>	
<b>Business Address</b>	
<b>Policy Period</b>	Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Retroactive Date</b>	This insurance does not apply to Professional Services which take place Before the Retroactive Date shown below. <b>Retroactive Date: MM/DD/YYYY</b>
<b>Premium PCF/Taxes</b>	
<b>Policy Limits</b>	<b>Each Claim Aggregate</b>
<b>Forms/Endorsements</b>	Form(s) and Endorsement(s) attached to this policy at inception:
<b>Your Agent</b>	

\_\_\_\_\_  
Authorized Signature



**Policy  
Issued  
By**

**[Company Name Inserted Here]**  
(Herein called "We" or "Us")  
Mailing Address: **[Company Address Inserted Here]**  
In the event of questions, please call **[Toll-Free Number Inserted Here]**

## **Chiropractor Professional Liability Policy Declarations Page**

**Policy Number**

**Named Insured**

**Business Address**

**Policy  
Period**

Effective from **MM/DD/YYYY to MM/DD/YYYY**  
12:01 A.M. Standard time at your address stated above

**Premium  
PCF/Taxes**

**Policy  
Limits**

**Each Claim  
Aggregate**

**Forms/  
Endorsements**

Form(s) and Endorsement(s) attached to this policy at inception:

**Your  
Agent**

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Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: <b>[Company Address Inserted Here]</b>
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### **Chiropractor Professional Liability Policy Cancellation Notice**

You are hereby notified that the policy designated below, including all attachments and endorsements, is cancelled as stated below in accordance with the terms and conditions of the policy.

<b>Policy Number</b>		
<b>Named Insured Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. standard at your address stated above
<b>Effective Date of Cancellation</b>		<b>MM/DD/YYYY</b> at 12:01 A.M. standard time at your address stated above.
<b>Reason for Cancellation</b>		
<b>Premium</b>		
<b>Your Agent</b>		

---

Authorized Signature



**Policy Issued By** | **[Company Name Inserted Here]**  
(Herein called "We" or "Us")  
Mailing Address: **[Company Address Inserted Here]**

### **Chiropractor Professional Liability Policy Cancellation Notice**

You are hereby notified that the policy designated below, including all attachments and endorsements, is cancelled as stated below in accordance with the terms and conditions of the policy.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. standard at your address stated above
<b>Effective Date of Cancellation</b>		<b>MM/DD/YYYY</b> at 12:01 A.M. standard time at your address stated above.
<b>Reason for Cancellation</b>		Non-payment of premium
<b>Payment Due</b>		In order to reinstate your policy, a payment of <b>\$XXX.XX</b> must be received by the cancellation date shown above. This amount includes a \$50 reinstatement fee.
<b>Payment Address:</b>		Remit payment to:
<b>Your Agent</b>		

*Lynne for PACO, Karen for PICA*  
Authorized Signature



<b>Policy Issued By</b>		<b>[Company Name Inserted Here]</b> (Herein called "We" or "Us") Mailing Address: <b>[Company Address Inserted Here]</b>
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## **Chiropractor Professional Liability Policy Endorsement**

In consideration of the premium stated below, it is agreed that the following items on the Declarations are amended as indicated. All other terms and conditions of the policy remain unchanged.

<b>Policy Number</b>		
<b>Named Insured</b>		
<b>Business Address</b>		
<b>Policy Period</b>		Effective from <b>MM/DD/YYYY to MM/DD/YYYY</b> 12:01 A.M. Standard time at your address stated above
<b>Policy Limits</b>		<b>Each Claim Aggregate</b>
<b>Effective Date of Endorsement</b>		<b>MM/DD/YYYY</b>
<b>Purpose</b>		Amend Premium to Reflect Full-Time Practitioner
<b>Premium Change</b>		
<b>Your Agent</b>		

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Authorized Signature

## **Rate Information**

Rate data does NOT apply to filing.

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Uniform Transmittal Document- Property & Casualty	<b>Review Status:</b> Approved	07-26-2007
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**Comments:**

**Attachments:**

Additional Forms Transmittal - 1.pdf  
Additional Forms Transmittal - 2.pdf  
AR - P&C Transmittal.pdf

<b>Satisfied -Name:</b>	AR Amendatory Endorsement	<b>Review Status:</b> Approved	07-26-2007
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**Comments:**

The AR Amendatory Endorsement is being submitted as "Informational Only." It was not affected by the changes made to our policy text in this filing.

**Attachment:**

OUMCAR-1030 Ed. 1-07.pdf

**PROPERTY & CASUALTY FORM FILING SCHEDULE**

(This form must be provided ONLY when making a filing that includes forms.)

(Do **not** refer to the body of the filing for the forms listing, unless allowed by the state.)

	This filing transmittal is part of Company Tracking #				
	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)				
	Form Name/ Description/Synopsis	Form# Include edition Date	Replacement Or Withdrawn	If replacement, give form # it replaces	Previous state filing number, (if required by state)
1 1			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
12			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
13			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
14			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
15			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
16			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
17			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
18			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
19			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
20			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

**PROPERTY & CASUALTY FORM FILING SCHEDULE**

(This form must be provided ONLY when making a filing that includes forms.)

(Do **not** refer to the body of the filing for the forms listing, unless allowed by the state.)

	This filing transmittal is part of Company Tracking #				
	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)				
	Form Name/ Description/Synopsis	Form# Include edition Date	Replacement Or Withdrawn	If replacement, give form # it replaces	Previous state filing number, (if required by state)
21			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
22			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
23			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
24			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
25			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
26			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
27			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
28			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
29			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
30			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

## Property & Casualty Transmittal Document

<b>1. Reserved for Insurance Dept. Use Only</b>	<b>2. Insurance Department Use only</b> a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

<b>3. Group Name</b>	<b>Group NAIC #</b>

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #

<b>5. Company Tracking Number</b>	
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**Contact Info of Filer(s) or Corporate Officer(s)** [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail

7. Signature of authorized filer	
8. Please print name of authorized filer	

**Filing information** (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	
10. Sub-Type of Insurance (Sub-TOI)	
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: <input type="text"/> Renewal: <input type="text"/>
15. Reference Filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	
19. Status of filing in domicile	<input type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

## Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

22. Filing Fees (Filer must provide check # and fee amount if applicable)  
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:  
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

\*\*\*Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

PC TD-1 pg 2 of 2

## FORM FILING SCHEDULE

(This form must be provided **ONLY** when making a filing that includes forms)  
 (Do **not** refer to the body of the filing for the forms listing, unless allowed by state.)

<b>1.</b>	<b>This filing transmittal is part of Company Tracking #</b>	
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<b>2.</b>	<b>This filing corresponds to rate/rule filing number</b> (Company tracking number of rate/rule filing, if applicable)	
-----------	---	--

<b>3.</b>	<b>Form Name /Description/Synopsis</b>	<b>Form # Include edition date</b>	<b>Replacement Or withdrawn?</b>	<b>If replacement, give form # it replaces</b>	<b>Previous state filing number, if required by state</b>
01			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1

# Arkansas Amendatory Endorsement PACO Assurance Company, Inc. Chiropractic Policy

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This endorsement modifies the provisions of this policy.

Section **Definitions**, the following is added as item (l) if this is an **Occurrence** Policy and item (m) if this is a **Claims-Made** Policy:

**Punitive Damages** mean damages that may be imposed to punish a wrongdoer and to deter others from similar conduct.

Section **Other Conditions**, item 7, **Cancellations**, is hereby deleted in its entirety and replaced with the following:

**Cancellations:** This policy may be cancelled by the **Named Insured** by surrender thereof to the **Company** or to any of its authorized agents or by mailing to the aforementioned written notice stating when thereafter the cancellation shall be effective. If cancelled by the **Insured**, the **Company** shall retain the customary short rate proportion of the premium.

This policy may be cancelled by the **Company** by mailing to the **Named Insured** at the address stated in the Declarations written notice stating when not less than thirty (30) days thereafter such cancellation shall be effective. However, if the **Company** cancels the policy because the **Insured** has failed to pay a premium when due, this policy may be cancelled by the **Company** by mailing a written notice of cancellation to the **Insured** stating when, not less than ten (10) days thereafter, such cancellation shall be effective. The notice shall contain the reason for such cancellation. The mailing of notice as aforementioned shall be sufficient notice and the effective date of cancellation stated in the notice shall become the end of the **policy period**. Delivery of such written notice by the **Named Insured**, the **Company** or its authorized agent shall be equivalent to mailing. If the **Company** cancels, earned premium shall be computed pro rata, except in the event of cancellation for nonpayment of premium due. Premium adjustment may be made at the time cancellation is effected or as soon as practicable thereafter. **Your** bankruptcy or insolvency shall not preclude **us** from asserting **our** right to cancel or nonrenew this policy.

After coverage has been in effect for more than sixty (60) days or after the effective date of a renewal policy, a notice of cancellation shall not be issued unless it is based on at least one (1) of the following reasons:

- (i) Nonpayment of premium;
- (ii) Fraud or material misrepresentation made by or with the knowledge of the **Named Insured** in obtaining the policy, continuing the policy, or in presenting a claim under the policy;
- (iii) The occurrence of a material change in the risk which substantially increases any hazard insured against after policy issuance;
- (iv) Violation of any local fire, health, safety, building, or construction regulation or ordinances with respect to any insured property or the occupancy of the property, which substantially increases any hazard insured against under the policy;
- (v) Nonpayment of membership dues in those cases where the bylaws, agreements, or other legal instruments of the insurer issuing the policy require payment as a condition of the issuance and maintenance of the policy; or
- (vi) A material violation of a material provision of the policy.

This policy may be non-renewed by mailing to the **Named Insured** at the address stated in the Declarations written notice stating when, not less than sixty (60) days thereafter, such non-renewal shall be effective, except in the case of non-payment of premium, in which case a ten (10) day notice shall be given.

The following is added to the **OTHER CONDITIONS** section of this policy:

**Notice of Rate Increase:** Written notice for premium increases in excess of twenty-five percent (25%) will be mailed to the agent at least sixty (60) days and to the Insured at least thirty (30) days prior to the expiration date of the policy.

### **THE FOLLOWING AMENDMENT APPLIES TO CLAIM-MADE POLICIES ONLY**

The **OPTIONAL EXTENSION COVERAGE (Tail Coverage)** section of the Claims-Made policy is hereby deleted in its entirety and replaced with the following:

In the event of termination of this policy by reason of non-renewal or cancellation, the **Named Insured** shall have the right to an automatic Extended Reporting Period or an Optional Extended Reporting Period as follows:

1) Automatic Extended Reporting Period

Upon termination of coverage, a 60-day automatic Extended Reporting Period will be provided by the insurer. The aggregate liability limit for this automatic Extended Reporting Period shall be equal to the amount of coverage remaining in the policy's annual aggregate liability limit.

2) Optional Extended Reporting Period

Within the 60-day automatic Extended Reporting Period and upon payment of an additional premium, the **Insured** shall have the option to extend the claims reporting period. The limit of liability in the policy aggregate for the optional extended reporting period shall be the greater of the amount of coverage remaining in the expiring policy aggregate or fifty percent (50%) of the aggregate at policy inception.

The **Named Insured** must request the Optional Extension Coverage in writing within sixty (60) days after the cancellation or termination date of this policy. The premium for this coverage will be based on the rules and rating plans in effect at the time of policy cancellation or termination. Written request for this coverage must include full payment of premium for the Optional Extension Coverage. If written request and premium payment are not submitted to the **Company** within (60) sixty days of cancellation or termination of this policy, the **Insured** will not be able to exercise this right at a later date and this offer of Optional Extension Coverage is withdrawn by the **Company**. This coverage cannot be cancelled by the **Company** or by the **Named Insured** after the Optional Extension Coverage is issued and the premium is paid in full.

If, however, this insurance is immediately succeeded by similar claims made insurance coverage on which the **retroactive date** is the same as, or earlier than, that shown in the Declarations of this policy, the Optional Extension Coverage shall be excess of such succeeding insurance.

The **Insured** has no express, implied, cumulative or vested right to purchase or obtain Optional Extension Coverage at no additional charge, except as provided in this policy.

The **Company** will provide Optional Extension Coverage to the **Named Insured** or the **Named Insured's** estate at no additional charge if any one of the following circumstances occur during the period of this policy:

1. The **Named Insured** dies; or
2. The **Named Insured** becomes permanently disabled and is unable or incapable of performing or continuing the practice of the chiropractic profession. Such disability:
  - a. Must be certified as such by a qualified medical practitioner;
  - b. Must have existed continuously for not less than six (6) months.

- c. Must have rendered the **Named Insured** unable or incapable of performing or continuing to perform the practice of chiropractic; and
  - d. Must be expected to be continuous and permanent.
3. The **Named Insured** retires from chiropractic practice at any age after having completed five consecutive years of coverage with the **Company**.
  4. The policy terminates for any reason other than cancellation for non-payment of premium or for underwriting reasons after the **Named Insured** has been continuously insured by the **Company** for 10 years. An **Insured** whose policy has been cancelled for non-payment of premium or for underwriting reasons will not be eligible to obtain Optional Extension Coverage at no additional charge. However, the Insured will still be eligible to purchase such coverage.

This Optional Extension Coverage is subject to all other terms, conditions, and exclusions of the policy. The Optional Extension Coverage only extends the time period during which a claim may be reported, and does not in any way increase the limits of liability of the policy.

## Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Original Date:</b>	<b>Schedule</b>	<b>Document Name</b>	<b>Replaced Date</b>	<b>Attach Document</b>
No original date	Form	Annual Policy Verification	07-12-2007	PG-DC-2010 Ed. 1-08 (Renewal Verification - Gen).pdf
No original date	Form	Annual Separate Limit Entity Coverage Verification	07-12-2007	PG-DC-2010CE Ed. 1-08 (Renewal Verification - Entity - Gen).pdf
No original date	Form	Annual Separate Limit Entity Coverage Verification	07-20-2007	PG-DC-2010CE Ed. 1-08 (Renewal Verification - Entity - Gen).pdf



Please mark any changes, additions or deletions in the area on the right, and answer all questions.

**1. Current Personal Information:**

**Name:** Lynne K. Cooke, DC  
**Primary Office:** 110 Westwood Place, Suite 0  
 Brentwood, TN 37027  
**Phone:** (615) 371-8776  
**Fax:** (615) 371-8775  
**Email:** **Please provide**  
**Mailing Address:** 110 Westwood Place, Suite 0  
 Brentwood, TN 37027  
**Billing Address:** 110 Westwood Place, Suite 0  
 Brentwood, TN 37027

**CHANGES TO Current Personal Information:**

<b>Name:</b>
<b>Primary Office:</b>
<b>Phone:</b>
<b>Fax:</b>
<b>Email:</b>
<b>Mailing Address:</b>
<b>Billing Address:</b>

- Change Limit of Liability: (select one)**  
 100/300  200/600  250/750  500/1M  
 500/1.5M  1M/1M  1M/3M  Other \_\_\_\_\_

**2. Policy Details:**

**Policy Number:** 06-2CH-0001234  
**Policy Period:** 1/1/2006 – 1/1/2007  
**Limits of Liability:** \$1,000,000 Per Occurrence/\$3,000,000 Aggregate  
**Policy Form:** Claims Made  
**County:** Williamson  
**Retro Date:** 1/1/1996

**3. Additional Risks:**

- Legal Entity Coverage:** Primm Springs Chiropractic, P.C.  
**Shared Limit of Liability:** \$1,000,000/\$3,000,000  
**Owners/Shareholders:** Lynne K. Cooke, DC  
 Mark D. Cooke, DC  
 Melissa A. Tiller, DC  
 James Q. Tiller, DC
- Legal Entity Coverage:** Brentwood Chiropractic Care, Inc.  
**Shared Limit of Liability:** \$1,000,000/\$3,000,000  
**Owners/Shareholders:** Lynne K. Cooke, DC

**CHANGES TO Additional Risks:**

<b>Legal Entity Name:</b>
<b>Remove Coverage?</b> <input type="checkbox"/> Yes
<b>Owners/Shareholders:</b>
<b>Legal Entity Name:</b>
<b>Remove Coverage?</b> <input type="checkbox"/> Yes
<b>Owners/Shareholders:</b>

\* For legal entities with separate limits of liability, please complete the enclosed Separate Limit Corporation Form.

**4. Practice Details: (Please answer all three questions)**

**(a)** Do you have ownership interest in any *additional* Professional Associations (P.A.), Professional Corporations (P.C.) or any other business entity **not listed above**?

<input type="checkbox"/> No
<input type="checkbox"/> Yes Business entity name: <input type="text"/>
Owner(s) name(s): <input type="text"/>
Entity Tax ID Number: <input type="text"/>
I would like to add a: <input type="checkbox"/> Separate Limit of Liability: (Additional Charge) <input type="checkbox"/> Shared Limit of Liability: (No Charge) <input type="checkbox"/> I decline coverage for this corporation

\* If you are requesting coverage for more than one business entity, please mark here  and attach additional entity information on a separate piece of paper.

(b) Do you practice with, associate with or assist another chiropractor or any other physician?  Yes  No

If yes, identify below:

NAME	RELATIONSHIP	INSURED BY

(c) Please list all active and inactive state licenses, and the number of current average patient contact hours under each license.

STATE/COUNTY	LICENSE NUMBER	# OF PATIENT CONTACT HRS PER WEEK

5. **Additional Coverages:**

- Regulatory Defense Coverage – Chiropractor No Charge/\$0 Limits: \$25,000/\$25,000
- Animal Chiropractic Endorsement \$500 Limits: \$25,000/\$25,000
- IN Patient Compensation Fund \$1,046 Limits: \$500,000/\$500,000

6. **Discounts/Surcharges:**

- Employed Practitioner 25% discount
- Part Time Practitioner 25% discount
- New Practitioner – 3<sup>rd</sup> year 35% discount
- Risk Management Home Study 10% discount

7. **Practice Survey:**

In the past twelve months, have you:

- (a) been notified of any claims or incidents?  NO  YES
- (b) had your professional chiropractic license subject to probation, suspended, revoked or had a complaint filed against you?  NO  YES
- (c) been involved in disciplinary proceedings or reprimanded by a governmental agency or professional association?  NO  YES
- (d) been convicted of or pleaded no contest to a violation of any law or ordinance other than a minor traffic offense?  NO  YES
- (e) been treated for alcoholism, drug abuse or chronic illness?  NO  YES
- (f) had privileges at any managed care facility suspended or revoked?  NO  YES

Do you:

- (g) Supply chiropractic professional services to animals?  NO  YES
- (h) Practice obstetrics, gynecological or urological services?  NO  YES

*For any questions answered "yes" for #7 above, please provide a narrative on a separate sheet of paper.*

8. **Payment Plans Available:** Please mark your selection below

- 10 Payment Plan (APW REQUIRED)** – 15% down payment of \$1,000.00 due on 1/1/2006. 9 remaining payments due every month. Includes a finance charge or installment fee.
- 5 Payment Plan** – 20% down payment of \$1,000.00 due on 1/1/2006. 4 remaining payments due every other month. Includes a finance charge or installment fee.
- 2 Payment Plan** – 50% down payment of \$1,500.00 due on 1/1/2006. Remaining payment due in 90 days. No finance charges or installment fees.
- Annual Payment Plan** – Full payment of \$2,000.00 due on 1/1/2006. No finance charge or installment fee.

I have answered these questions to the best of my knowledge. I have not withheld any information that might influence the decision making ability of {CO\_NAME}. My signing of the application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I authorize {COMPANY} to release all pertinent information which may bear upon my insurability to {COMPANY}.

**Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance or statement of claim, containing any materially false information or conceals for the purpose of misleading, information concerning any facts material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution, and confinement in state prison.**

Your Signature \_\_\_\_\_

Date



**Annual Separate Limit Entity Coverage Verification**  
 Please contact us toll-free at 1-800-423-1504, ext. 7 with any questions

Please mark any changes, additions, or deletions to the below information and answer all questions:

**1. Current Entity Information**

**Name:** Nashville Chiropractic Clinic, P.C.  
**Primary Office:** 12345 Main Street, Nashville, TN 37215  
**Phone:** 615-321-9876 "Please provide" if not on file  
**Fax:** 615-321-8765 "Please provide" if not on file  
**Email:** gsmith@abc.com "Please provide" if not on file  
**Mailing Address:** Not on File  
**Billing Address:** 12345 Main Street, Nashville, TN 37215

**2. Policy Details**

**Policy Number:** 1CP0001235  
**Limits of Liability:** \$1,000,000 Per Occurrence/\$3,000,000 Aggregate

**3. Owners/Shareholders:**

George W. Smith, DPM  
 Janet S. Smith, DPM  
 George W. Smith, Jr., DPM

<b>CHANGES TO Current Entity Information:</b>
<b>Name:</b>
<b>Primary Office:</b>
<b>Phone:</b>
<b>Fax:</b>
<b>Email:</b>
<b>Mailing Address:</b>
<b>Billing Address:</b>
<b>Change Limit of Liability:</b> <input type="checkbox"/> (select one) <input type="checkbox"/> 100/300 <input type="checkbox"/> 200/600 <input type="checkbox"/> 250/750 <input type="checkbox"/> 500/1M <input type="checkbox"/> 500/1.5M <input type="checkbox"/> 1M/1M <input type="checkbox"/> 1M/3M <input type="checkbox"/> Other _____

Have any changes been made to the corporation owners/shareholders in the past twelve months?			
<input type="checkbox"/> NO			
<input type="checkbox"/> YES, identify changes below:			
NAME	RELATIONSHIP	INSURED BY	Check One:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Add <input type="checkbox"/> Delete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Add <input type="checkbox"/> Delete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Add <input type="checkbox"/> Delete

**4. Practice Survey:**

In the past twelve months, have you:  
 a. been notified of any claims or incidents against the corporation?  NO  YES

**5. Payment Plans Available:**

- Please select the same plan as your individual policy.
- 10 Payment Plan (APW REQUIRED)** – 15% down payment of \$1,000.00 due on 1/1/2006. 9 remaining payments due every month. Includes a finance charge or installment fee.
  - 5 Payment Plan** – 20% down payment of \$1,000.00 due on 1/1/2006. 4 remaining payments due every other month. Includes a finance charge or installment fee.
  - 2 Payment Plan** – 50% down payment of \$1,500.00 due on 1/1/2006. Remaining payment due in 90 days. No finance charges or installment fees.
  - Annual Payment Plan** – Full payment of \$2,000.00 due on 1/1/2006. No finance charge or installment fee.

I have answered these questions to the best of my knowledge. I have not withheld any information that might influence the decision making ability of {CO\_NAME}. My signing of the application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I authorize {COMPANY} to release all pertinent information which may bear upon my insurability to {COMPANY}.

Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance or statement of claim, containing any materially false information or conceals for the purpose of misleading, information concerning any facts material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution, and confinement in state prison.

Your Signature \_\_\_\_\_ Date \_\_\_\_\_



**Annual Separate Limit Entity Coverage Verification**  
 Please contact us toll-free at 1-800-423-1504, ext. 7 with any questions

Please mark any changes, additions, or deletions to the below information and answer all questions:

**1. Current Entity Information**

**Name:** Nashville Chiropractic Clinic, P.C.  
**Primary Office:** 12345 Main Street, Nashville, TN 37215  
**Phone:** 615-321-9876 "Please provide" if not on file  
**Fax:** 615-321-8765 "Please provide" if not on file  
**Email:** gsmith@abc.com "Please provide" if not on file  
**Mailing Address:** Not on File  
**Billing Address:** 12345 Main Street, Nashville, TN 37215

**2. Policy Details**

**Policy Number:** 1CP0001235  
**Limits of Liability:** \$1,000,000 Per Occurrence/\$3,000,000 Aggregate

**3. Owners/Shareholders:**

George W. Smith, DPM  
 Janet S. Smith, DPM  
 George W. Smith, Jr., DPM

**CHANGES TO Current Entity Information:**

<b>Name:</b>
<b>Primary Office:</b>
<b>Phone:</b>
<b>Fax:</b>
<b>Email:</b>
<b>Mailing Address:</b>
<b>Billing Address:</b>
<b>Change Limit of Liability:</b> <input type="checkbox"/> (select one) <input type="checkbox"/> 100/300 <input type="checkbox"/> 200/600 <input type="checkbox"/> 250/750 <input type="checkbox"/> 500/1M <input type="checkbox"/> 500/1.5M <input type="checkbox"/> 1M/1M <input type="checkbox"/> 1M/3M <input type="checkbox"/> Other _____

Have any changes been made to the corporation owners/shareholders in the past twelve months?																
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Your Signature \_\_\_\_\_ Date \_\_\_\_\_