HOLISTIC HEALTH PRACTITIONER MEMBERSHIP & PROFESSIONAL LIABILITY INSURANCE PROGRAM

AINM American Institute of Naturopathic Medicine

AHS AMERICAN HEALTH SOURCE

CONTACT DATA

Full Name (First, Middle, Last) _____ Practice / Clinic Name _____

Office or Mailing Address (include Suite #) _____ City _____ State _____ Zip _____

Office Phone _____ Alternate Phone (Home, Cell, etc.) _____ Fax _____ Email _____

Cert. Current? ☐ Yes ☐ No

HHP Certification Number(s) _____ Issued By: ☐ AINM ☐ Other HHP School and Location _____ Year Graduated _____

PROFESSIONAL INFORMATION

1. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If *YES*, explain) ☐ Yes ☐ No
2. Has any agency or association investigated or taken any other action against you or your certification? (If *YES*, explain) ☐ Yes ☐ No
3. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If *YES*, explain) ☐ Yes ☐ No
4. Have you ever used any drug or substance that interfered with your ability to perform HHP duties? (If *YES*, explain) ☐ Yes ☐ No
5. Have you ever been charged with or convicted of any violation of the law other than a minor traffic offense? (If *YES*, explain) ☐ Yes ☐ No
6. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics or make a differential diagnosis? (If *YES*, explain) ☐ Yes ☐ No
7. Have you ever provided nutritional, herbal or HHP services to a professional athlete? (If *YES*, explain) ☐ Yes ☐ No
8. Do you provide any service or advice other than as taught in the HHP schools and colleges? (If *YES*, explain) ☐ Yes ☐ No
9. Do you currently carry HHP Liability insurance? ☐ Yes ☐ No If *YES*, Carrier: _____ Policy Expires _____
10. List other health professions you are licensed to practice (RN, LMT, LAc, etc.) _____
11. Who provides your malpractice insurance for that profession? _____ Policy Expires: _____
12. Your HHP liability insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____
13. List any entity you want as an additional insured *(cost is $25 /entity)*: _____

MEMBERSHIP OPTIONS AND PAYMENT

Professional Membership includes $1 million / $3 million Professional & Premises Liability Coverage.

☐ 1st Year Professional	@ $435 =	
☐ All Other Years	@ $535 =	
☐ ANIM Membership only	@ $100 =	
☐ Additional Insured	@ $ 25 =	
☐ General Liability	@ $ 49 =	
☐ Business Personal Property ($10,000 Limit - Lloyd's of London Policy – Incl. Tax)	@ $110 =	
TOTAL AMOUNT DUE:		

☐ Check ☐ MasterCard ☐ Visa ☐ AMEX

Card #: _____ Expires: _____

SIGN THEN FAX OR MAIL APPLICATION

I hereby apply for coverage. If provided, charge my credit card for the amount indicated. I hereby declare that the above statements are true, and I have not misstated or suppressed any facts. I agree and understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of my policy. I understand that this is a Claims Made policy *(Does not apply if your Claims Reporting Basis is Occurrence)* which will only cover claims made during the policy period arising out of the rendering, or of failure to render, professional services subsequent to the retroactive date. I understand that if the policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless Extended Coverage is purchased within 30 days after termination. I understand that there is no guarantee that coverage will be renewed. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, threats, or filings of lawsuits.

SIGN: _____ DATE: _____

REMIT TO: **AHS** (American Health Source)
2040 RAYBROOK SE, SUITE 103 GRAND RAPIDS MI 49546
888-375-7245 - PHONE 616-575-9066 - FAX