THE DOCTORS' INSURANCE AGENCY

Application for Colon Hydrotherapy
Individual Professional Liability Coverage

CONTACT & COVERAGE INFORMATION

Applicants full name (First, Middle, Last) _____ Practice/Clinic Name _____

Office Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Office phone _____ Cell phone _____ Email _____ Website _____

Colon Hydrotherapy License/Certificate _____ State Issued _____ Date Issued _____ Name of School/Program _____ Hours Training _____ Year Graduated _____

Are you a member of I-ACT, I-ACH or GPACT? ☐ Yes ☐ No # of hydrotherapists _____ How long in business? _____ Square feet _____

Do you have operations other than Colon Hydrotherapy?_____ If yes, provide details:_____

Do you have insurance for these operations? _____ Name of insurance company: _____

Do you need coverage for massage therapy? _____ Names of providers providing massage therapy: _____

Do you need General Liability? _____ If no, what company provides your general liability coverage? _____

Do you need Landlord/Lessor to be named as Additional Insured? ____ If yes, name/address: _____

Do you need to cover a supporting doctor? If yes, list name: _____

PROFESSIONAL INFORMATION

1. Have you ever experienced a liability claim arising from any professional activity whether insured or not? (If yes, provide details) ☐ Yes ☐ No
2. Has any agency or association ever investigated or taken any action against you or your license/certificate? (If yes, explain) ☐ Yes ☐ No
3. Do you use colon hydrotherapy to treat any conditions, diseases or injuries or do you make any diagnoses? (If yes, explain) ☐ Yes ☐ No
4. Before providing colon hydrotherapy do you determine if the person has a history of colon cancer, bleeding hemorrhoids, hemorrhoids, bloody diarrhea, diverticulitis, colitis, ulcerative colitis, rectal abnormalities/fissures or is receiving treatment for their kidneys? (If yes, explain) ☐ Yes ☐ No
5. Do you ever provide colon hydrotherapy services to minors (persons under the age of 18)? ☐ Yes ☐ No
6. Is the colon hydrotherapy machine you use approved by the FDA? ☐ Yes ☐ No If yes, FDA approval number: _____
7. Are you certified on the equipment that you use? ☐ Yes ☐ No
8. Do you comply with contraindications restrictions that are listed in the owner's manual of the equipment you use? ☐ Yes ☐ No
9. How do you sterilize all equipment and materials prior to use? _____
10. Do you dispose of the nozzle after each patient? ☐ Yes ☐ No If no, explain: _____

The Doctors Insurance Agency/O'Brien Insurance Services, Inc.
6 Hamilton Landing, Suite 170, Novato, CA 94949
(800)553-9293 Fax 415-506-3031 info@doctorsagency.com
www.doctorsagency.com

AGREEMENTS AND SIGNATURE

11. I agree to use the carrier approved consent and medical history forms that are available at www.medispa-ins.com.

_____
Signature

NOTE: All questions must be answered. Failure to disclose claims history could invalidate coverage.

12. Do you currently have insurance coverage? ☐ Yes ☐ No If yes, indicate the following:

Insurer	Policy No.	Liability Limits	Premium	Expiration Date

If Claims Made, most recent retroactive date: _____

13. Has any malpractice allegation ever been asserted against you, 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? ☐ Yes ☐ No
If yes, explain on a separate sheet.

14. Have you ever had liability insurance refused, declined, canceled or accepted on special terms: ☐ Yes ☐ No
If yes, explain on a separate sheet.

15. Are you requesting coverage for any other services outside of administering colon hydrotherapy? ☐ Yes ☐ No
If yes, explain on a separate sheet.

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

_____ _____
APPLICANT SIGNATURE TITLE

_____ _____ _____
DATE REQUESTED EFFECTIVE DATE LIABILITY LIMIT REQUESTED