AYURVEDIC PRACTITIONER

Application for Membership

CONTACT INFORMATION

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

Office Address (Include Suite #) _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Office Phone _____ Cell Phone _____ Fax _____ Email _____

PRACTICE BACKGROUND

1. List ***current*** Ayurveda certification you hold (attach a copy or additional sheets if needed):

   Certification Number: _____ Completed (Mo/Yr): ____/____ Hours of Training: _____

2. List any other health licenses or certifications you hold (or indicate none): ❒ None ❒ RN ❒ LMT ❒ Nutrition ❒ Other _____

3. Do you understand and agree that your Ayurveda practice must only address a person's general well-being through a program of Nutrition, Lifestyle Recommendations, Yoga and Meditation, and when applicable and permitted by state law, Massage / Bodywork, and may not involve treating any condition, disease or injury? (*If NO, explain*) ❒ Yes ❒ No

4. Do you intend to provide massage as a part of your practice? (*If YES, separate Massage application required*) ❒ Yes ❒ No

(If you answer Yes to any of the following, attach a detailed explanation including status, dates, and outcomes.)

7. Has any malpractice or professional negligence claim or allegation ever been asserted against you or your associates? ❒ Yes ❒ No

8. Are you aware of any event or indication suggesting a claim may be made against you or that your services might have been deficient or caused harm? ❒ Yes ❒ No

9. Has any agency or association ever investigated or taken any action against you or your certification? ❒ Yes ❒ No

10. Have you ever had professional liability insurance denied, canceled, or accepted on special terms? ❒ Yes ❒ No

11. Have you been charged with or convicted of violating any law other than a minor traffic offense? ❒ Yes ❒ No

12. Have you ever provided services or guidance to clients/patients when your ability to perform your duties was compromised because of a condition, or your use of an intoxicant, medication, or other drug? ❒ Yes ❒ No

Declaration: I, the applicant, represent that: 1) I am applying for membership/coverage; 2) I signed/typed my name in the place(s) provided herein; and 3) The above statements are true and I have not misstated or suppressed any facts. I understand that: 1) If coverage is granted, my Policy is issued in reliance upon such statements; 2) Such statements are deemed material; 3) Untrue statements could void my insurance; 4) This declaration shall be the basis of, and form a part of my Policy; 5) There is no guarantee that coverage will be renewed; and 6) The Policy requires that I report, in writing, within 3 days or as soon as practicable, incidents reasonably likely to involve this insurance, including oral or written patient complaints, threats, or lawsuits.

Sign here: _____ **Date:** _____

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COVERAGE OPTIONS AND PAYMENT

PROFESSIONAL LIABILITY LIMITS: $1,000,000 PER CLAIM / **$3,000,000** AGGREGATE

PROFESSIONAL LIABILITY INSURANCE, CLAIMS MADE REPORTING BASIS

1. Effective Date: Coverage, if approved, is effective the date the app is received. For a later date, specify date here: _____

2. List below to add any entity as an Additional Insured (e.g. your Employer, Landlord, etc.). Cost is $10 per entity:

_____

_____

3. Do you want optional Business Personal Property (BPP) coverage? ❒ Yes ❒ No

BPP covers physical property of your practice up to $10,000 limit, rate for coverage is $100.00. Address required)

If ***Yes***, list Address: _____

4. If you want Premises Liability coverage, indicate where you want coverage to apply: ❒ At Office Address ❒ At Alternate (list below)

Alternate Address (If applicable): _____

5. Who provides your current professional liability coverage? _____ Policy Expires: _____

Payment Detail (Refer to coverage proposal)

Amount Due	
Membership and Coverage: (**$396** Annual / **$109** Quarterly)	$ 109.00
❒ Additional Insured @ $10.00 / entity =	$ 0.00
❒ Premises Liability @ $75 / location =	$ 0.00
❒ Business Personal Property @ $103.25(1) =	$ 0.00
Total Payment Remitted:	$ 109.00

(1) $10,000 Limit – Lloyd's of London Policy – Incl. Tax

(Please review the Policy, which is available upon request, for details pertaining to coverage, including limits, conditions, exclusions, etc.).

3. Credit Card or ACH (Complete applicable section.)

Credit Card Type: ❒Visa ❒ MasterCard ❒ American Express

Name on Card: _____

Card #: _____

Expires: _____

ACH Payments from: ❒ Personal Account ❒ Business Account

Name on Account _____

Account #: _____

Bank Name: _____

Bank Routing #: _____

Bank City: _____

AGREEMENT & SIGNATURE

Claims Made Policy: I understand that if coverage is granted, my Policy will be limited to claims made against me during the Policy period arising out of the rendering of, or failure to render, professional services subsequent to the retroactive date. I understand that the Claims Made option provides 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 I purchase Extended Coverage within 30 days after termination.

Authorization: If coverage is granted, I authorize you to: 1) Process payments when due, including any installments, by charging the Credit Card or debiting the Bank Account provided, in compliance with issuer agreements and U.S. law, and agree that this authority will remain in effect until I have canceled it in writing; 2) Request and receive information about me, for any underwriting or claim-related inquiry, from any professional association, licensing board or health care organization; and 3) Communicate with me related to my coverage/membership through Email, Fax, Phone and/ or Text.

Sign here: _____ **Date:** _____

Submit Application: **By Email**: info@councilsupport.com **By Fax**: 714-571-1863