IAHP Touch Therapy

Professional Liability Coverage Application

$1,000,000 / $3,000,000 Coverage: $99

The IAHP Touch Therapy Coverage Program is offered in conjunction with the American Massage Council (AMC) Risk Purchasing Group, and has been underwritten by Allied Professionals Insurance Company, a Risk Retention Group, Inc. Complete this AMC member application to enroll in the program.

First Name _____ Last Name _____ Practice Name (If applicable) _____ Phone _____

Address _____ City _____ State _____ Zip _____ Fax _____

1. Designations – List current Professional Designations and details as indicated below.

Professional Designation (D.C., L.Ac., D.O., L.M.T, etc.)	License Number	Issue Date Month / Yr	License Current?	Current Malpractice Carrier (If "None" indicate "None")	Policy Expires Month / Yr
			☐ Yes ☐ No		
			☐ Yes ☐ No		

2. Touch Therapy – Provide details regarding your use of IAHP or Other Touch Therapy modalities, and related training.

Name of Therapy	% of Practice	Applicable IAHP and/ or Other Training Completed	Training Hours

3. Has any malpractice claim or proceeding ever been brought against you, your associates or employees, or are you aware of any circumstance that would give rise to such a claim? (If *Yes*, attach explanation) ☐ Yes ☐ No
4. Has any government agency investigated, suspended, revoked, or taken any other action against your license to practice touch therapy? If *Yes*, explain. ☐ Yes ☐ No
5. Have you ever had malpractice insurance refused, declined, canceled, or accepted on special terms? If *Yes*, explain. ☐ Yes ☐ No
6. Have you ever used any intoxicant, narcotic, or other psychoactive drugs to the extent that it has interfered with your ability to perform professional duties; or used any illegal drug in the past year? If *Yes*, explain. ☐ Yes ☐ No
7. Have you ever been convicted of any violation of the law other than a minor traffic offense? If *Yes*, explain. ☐ Yes ☐ No
8. Has any professional association suspended, revoked, or taken any other adverse action against you or your membership in any such association? If *Yes*, explain. ☐ Yes ☐ No
9. Do you do colonic irrigations, treat cancer, epilepsy, practice obstetrics or make a differential diagnosis? If *Yes*, explain. ☐ Yes ☐ No
10. Do you use any technique or therapy that is not currently taught by professional schools or programs? If *Yes*, explain. ☐ Yes ☐ No

Send Application & Payment To:	**Payment Type** *(If Paying by Credit Card you may Fax your App)*	**Enter Amount Paid**
IAHP Touch Therapy Program	Pmt Type: ☐ MC ☐ Visa ☐ Am Ex ☐ Check	Policy $ 99.00
1851 East First Street, # 1160	Card #: _____ Expires _____	Add Insured $
Santa Ana CA 92705	Name on Card:	Total $
Additional Insureds - List additional person / entity you need to add to your coverage ($25 / person for first two, all others are free):		

MEMBER DECLARATION: I hereby apply for Touch Therapy malpractice insurance. I understand that while I may hold a variety of professional healthcare designations, I am only seeking coverage for touch therapy, and am not seeking coverage for the practice of Medicine or any other element within the scope of any professional designation, except Touch Therapy. I understand that the Policy for which I am applying neither covers the misdiagnosis of or failure to diagnose any disease or condition, and that the premium paid for this Policy could not and does not provide adequate payment to cover the cost of professional liability coverage beyond Touch Therapy. I declare that the statements made in my Risk Purchasing Group Membership Application are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis for, and form a part of my malpractice insurance Policy. I understand that untrue statements could void my insurance Policy. Finally, I understand that I am applying for a Claims Made policy, which means that, unless I purchase an Extended Reporting Period Endorsement to permit reporting of a claim after coverage is terminated, coverage is provided only for incidents which occur during the policy period, and then only for claims made during the policy period.

SIGN _____ ◄ **DATE:** _____ ◄