



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.

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

1. Designations – List current professional designations and details as indicated below.

Professional Designation (D.C., L.Ac., D.O., L.M.T., ect.)	License Number	Issue Date Month/Yr	License Current? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Malpractice Carrier (if "None" indicate "none")	Policy Expires Month/Yr
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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 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

4. Has any agency or association investigated or taken any other action against you or your license / certification? (If YES, explain) Yes No

5. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If YES, explain) Yes No

6. Have you ever used any drug or substance that interfered with your ability to perform Massage duties? (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. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics, or make a differential diagnosis? (If YES, explain) Yes No

9. Are you providing any Massage service that was not a part of your massage school training program? (If YES, explain) Yes No

10. To add Premises Liability (\$50 / location), list address here: _____

11. List any entity you want as an additional insured (\$10 / entity): _____

12. Your Massage insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____

PAYMENT

Membership and Coverage	\$99.00
Additional Insured @ \$10 / Entity	-----
Premises Liability @ \$50 / Location	-----
TOTAL PAYMENT REMITTED	-----

Pmt Type: Check MasterCard Visa AMEX

Card #: _____ Exp: _____

AGREEMENT & SIGNATURE

\$1,000,000 / \$3,000,000 PROFESSIONAL LIABILITY COVERAGE

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:** _____

FAX OR MAIL COMPLETED APPLICATION TO:

IAHP TOUCH THERAPY PROGRAM
 1100 W. Town & Country Rd, Suite 1400
 Orange, CA 92868
 800-860-8330 Phone 714-571-1863 Fax