

ALTERNATIVE THERAPIES SUPPLEMENT

PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

1. APPLICANT PROFESSIONAL SERVICES & MEDICAL PRACTICE

- a) Acupuncture, for analgesia, asthma, nicotine addiction, headache, low back pain (circle each that apply) ... [ ] Yes [ ] No
If yes, do you only use disposable needles? ... [ ] Yes [ ] No (If no, attach details.)
Do you use lasers on the acupuncture points? ... [ ] Yes [ ] No (If yes, we will need a copy of your training - please attach.)
b) Electro acupuncture..... [ ] Yes [ ] No
c) Acupressure ..... [ ] Yes [ ] No
d) Ayurvedic Medicine ..... [ ] Yes [ ] No
e) Biofeedback..... [ ] Yes [ ] No
f) Chelation Therapy ..... [ ] Yes [ ] No
If yes, indicate No. of annual treatments \_\_\_\_\_ and what is your certification, or attach a copy of your training \_\_\_\_\_ date certified \_\_\_\_/\_\_\_\_/\_\_\_\_.
g) Chiropractic ..... [ ] Yes [ ] No
If yes, do you perform manipulation under anesthesia? ..... [ ] Yes [ ] No
h) Homeopathy ..... [ ] Yes [ ] No
i) Hypnosis ..... [ ] Yes [ ] No
j) Invasive Procedures (If yes, attach details.) ..... [ ] Yes [ ] No
k) Light Therapy..... [ ] Yes [ ] No
l) Massage Therapy..... [ ] Yes [ ] No
m) Megavitamins ..... [ ] Yes [ ] No
If yes, do you sell these products? .... [ ] Yes [ ] No (If yes, attach details.)
n) Moxibustion, direct ..... [ ] Yes [ ] No
o) Naturopathy..... [ ] Yes [ ] No
p) Nutritional Supplements ..... [ ] Yes [ ] No
If yes, do you sell these products? .... [ ] Yes [ ] No (If yes, attach details.)
q) Osteopathy ..... [ ] Yes [ ] No
r) Pharmacological & Biological Treatments ..... [ ] Yes [ ] No
If Chelation Therapy, refer to Item (f.) (If Others, attach details.)
s) Reflexology ..... [ ] Yes [ ] No
t) Reiki ..... [ ] Yes [ ] No
u) Therapeutic Touch ..... [ ] Yes [ ] No
v) Traditional Chinese Medicine..... [ ] Yes [ ] No
w) Western Herbalism..... [ ] Yes [ ] No
If yes, do you sell these products? .... [ ] Yes [ ] No (If yes, attach details.)
x) Other (If yes, attach details.) ..... [ ] Yes [ ] No

2. TESTING OPERATIONS

- a) Do you participate in any nutritional or pharmaceutical testing programs? [ ] Yes [ ] No. If yes, are they FDA approved? [ ] Yes [ ] No (If No, attach details.)

3. ADDITIONAL INFORMATION

Please attach: Copy of brochure, or other descriptive literature and Resume

I understand information submitted herein becomes a part of my General Application and is subject to the same representation and conditions.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

\*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.