



# Application for Membership



## ➤ Malpractice Coverage Information: (\$1,000,000/\$3,000,000 Limits)

Full Name (Please Print Legibly)		Telephone Number	Fax Number	
Permanent Address		City	State	Zip Code
Massage License # (s)	State(s) Issued	Massage School Attended	Graduated On	Hrs. School Training

## ➤ Professional Information (For questions 1 through 8: If you answer yes, provide full details on a separate sheet)

- Has any action, such as a suit, arbitration or other claim or proceeding, been brought against you your massage partnership your massage corporation, associates or employees for alleged malpractice, or are you aware of any circumstance that could give rise to such action being brought?  Yes  No
- Has any government agency investigated, suspended, revoked, or taken any other action against your license to practice massage?  Yes  No
- Have you ever had malpractice insurance refused, declined, canceled, or accepted on special terms?  Yes  No
- 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?  Yes  No
- Have you ever been convicted of any violation of the law other than a minor traffic offense?  Yes  No
- Has any professional association suspended, revoked, or taken any other adverse action against you or your membership in any such association?  Yes  No
- Do you do colonic irrigations, treat cancer, epilepsy, practice obstetrics or make a differential diagnosis?  Yes  No
- Do you use any technique or therapy that is not currently taught in the massage schools and colleges?  Yes  No
- Is your massage license issued by:  State  City  N/A Is your massage license current? (Attach Copy)  Yes  No
- Do you wish coverage for any other person or entity (additional insured rates apply)?  Yes  No
- Name of Additional Insured: \_\_\_\_\_  
Address of Additional Insured: \_\_\_\_\_
- When do you want your massage insurance to be in effect (may not be before date your app is received)? \_\_\_\_\_
- List other health professions you are licensed to practice (DC, L.Ac., etc.) \_\_\_\_\_  
Provide the name of your malpractice insurance carrier for that profession: \_\_\_\_\_ Expires: \_\_\_\_\_
- Do you currently carry massage insurance?  Yes  No If yes, Carrier: \_\_\_\_\_ Expires: \_\_\_\_\_
- List all massage association memberships: \_\_\_\_\_

## ➤ Signatures (Signatures are required in three places.)

**NO FALSE STATEMENTS:** I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my massage professional liability insurance policy. I understand that untrue statements could void my insurance policy.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**CLAIMS-MADE ONLY:** I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the insured or insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force) unless the insured purchased an Extended Coverage Policy within 30 days after termination.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS:** I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe massage practices may be based in part on information provided by me on future follow-up data sheets or during future pre-arranged office inspections. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## ➤ Mail or fax your app and \$99 to:

**American Massage Council**  
1851 East First Street Suite 1160  
Santa Ana, CA 92705  
800-500-3930 · 714-571-1863 FAX

## ➤ For credit card payment, complete the following:

Card #: \_\_\_\_\_ Expires: \_\_\_\_\_

You are authorized to charge the above card for \$99 to activate American Massage Council coverage. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: \_\_\_\_\_