

SERFF Tracking Number: CNAC-125501466 State: Arkansas
Filing Company: American Casualty Company of Reading - PA State Tracking Number: #222624 \$50
Company Tracking Number: 08-F2201
TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0001 Acupuncture
Made/Occurrence
Product Name: Healthcare Providers Service Organization - Acupuncturists
Project Name/Number: Acupuncturists - new class /20082201

Filing at a Glance

Company: American Casualty Company of Reading - PA

Product Name: Healthcare Providers Service SERFF Tr Num: CNAC-125501466 State: Arkansas

Organization - Acupuncturists

TOI: 11.0 Medical Malpractice - Claims

SERFF Status: Closed

State Tr Num: #222624 \$50

Made/Occurrence

Sub-TOI: 11.0001 Acupuncture

Co Tr Num: 08-F2201

State Status: Fees verified and received

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding

Author: John Lockhart

Disposition Date: 03/19/2008

Date Submitted: 02/21/2008

Disposition Status: Approved

Effective Date Requested (New): 04/01/2008

Effective Date (New):

Effective Date Requested (Renewal): 04/01/2008

Effective Date (Renewal):

State Filing Description:

General Information

Project Name: Acupuncturists - new class

Status of Filing in Domicile: Pending

Project Number: 20082201

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 03/19/2008

State Status Changed: 03/19/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Healthcare Providers Services Organization Risk Purchasing Group Program - New Class - Acupuncturists New Forms

On behalf of American Casualty Company of Reading, PA we hereby submit for your review and approval the captioned forms, rates and rules for use with our Healthcare Providers Services Organization Program currently on file with your

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department.

Attached for your review are 2 forms:

1. GSL2542XX (01/08) Exclusion of Procedures Treatments or Therapies Acupuncturist Endorsement. This endorsement amends the policy by adding an exclusion for act, errors or omissions involving specified procedures, treatments or therapies
2. G-142832-A (2/08) Acupuncturist Professional Liability Insurance Application

Company and Contact

Filing Contact Information

John Lockhart, Regulatory Filings Technician john.lockhart@cna.com
 40 Wall Street (877) 269-3277 [Phone]
 New York, NY 10005 (212) 440-2877[FAX]

Filing Company Information

American Casualty Company of Reading - PA CoCode: 20427 State of Domicile: Pennsylvania
 40 Wall Street Group Code: 218 Company Type:
 8th Floor
 New York, NY 10005 Group Name: State ID Number:
 (212) 440-3478 ext. [Phone] FEIN Number: 23-0342560

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Casualty Company of Reading - PA	\$0.00	02/21/2008	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
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0000222624 \$50.00 02/14/2008

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	03/19/2008	03/19/2008

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Exclusion of Procedures, Treatments or Therapies	Approved	Yes
Form	Acupuncturist Professional Liability Insurance Application	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Exclusion of Procedures, Treatments or Therapies	GSL2542 XX	01/2008	Endorsement/Amendment/Conditions		0.00	GSL2542XX_012008_Exclusion of Procedures Treat or Ther.pdf
Approved	Acupuncturist Professional Liability Insurance Application	G-142832-A	02/2008	Application/ New Binder/Enrollment		0.00	G142832-A_022008_Acupuncturist Application.pdf

**HEALTHCARE PROVIDERS
PROFESSIONAL LIABILITY COVERAGE PART ENDORSEMENT**

**Exclusion of Procedures, Treatments or Therapies
Acupuncturists**

In consideration of the premium paid, it is agreed that the **PROFESSIONAL LIABILITY COVERAGE PART, Section V. Exclusions**, is amended to add the following:

We will not defend any **claim** for, or pay any amounts, including **claim expenses**, based on, arising out of, or related to any of **your** acts, errors or omissions involving the procedures, treatments or therapies as designated below:

- Acupuncture as anesthesia during surgical procedures
- Chiropractic manipulation and/or adjustment
- Use of Cold Laser
- Colonic irrigations
- Dehydration of hemorrhoids
- Direct Moxibustion
- Fever therapy
- Gemstone therapy
- Use of Reusable needles
- Use of Toftness device
- Treatment of animals
- Treatment or reduction of a fracture
- X-ray, microwave and radium
- Maibotsushin, Okibari or any prolonged insertion of needles (ear tacs or seeds are acceptable)
- Obstetrics or gynecology, including delivery of babies or care of newborn infants until they are fourteen (14) days old.
- Production, promotion, solicitation, testing, selling or manufacture of vitamins, minerals, herb supplements and nutritional supplements, medicinal supplements and nutritional supplements
- Any service, treatment, advice or instruction for the purpose of skin or appearance enhancement, personal grooming, cosmetic procedures and salon or spa services including botox or its homeopathic equivalent or any fluid injection
- Treatment of cancer, epilepsy, or acquired immune deficiency syndrome, except that treatment is not excluded if such treatment is solely to alleviate pain and during the entire period of treatment, the patient is under the care of a licensed physician for the condition or disease and **you** do not interfere with the course of treatment recommended by such patient's treating physician.

This endorsement is a part of **your** policy and takes effect on the effective date of **your** policy, unless another effective date is shown below. All other provisions of the policy remain unchanged.

<i>Must Be Completed</i>	
ENDT. NO.	POLICY NO.

<i>Complete Only When This Endorsement Is Not Prepared with the Policy Or Is Not to be Effective with the Policy</i>	
ISSUED TO	ENDORSEMENT EFFECTIVE DATE



Acupuncturist Professional Liability Insurance Application – Claims-Made Form

Yes, I want Acupuncturist Professional Liability Insurance, based on the limits of liability I have selected.

ACU_A5FS7F7__ __

A. GENERAL INFORMATION

Please answer ALL questions and SIGN and DATE this form. Incomplete requests cannot be processed.

1. Name: _____ Social Security Number or Tax ID#: _____
 Home Address: _____ Date of Birth: ____/____/____
MM DD YYYY
 City: _____ Day Telephone #: (____) _____
 State: _____ Zip: _____ Night Telephone #: (____) _____
 County: _____ Fax: (____) _____
 E-Mail _____

B. PRACTICE INFORMATION

2a. I primarily work in/at (choose one):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Comm. Health Facility (02) | <input type="checkbox"/> Hospice (06) | <input type="checkbox"/> Outpatient Facility (16) | <input type="checkbox"/> School/Health Dept. (11) |
| <input type="checkbox"/> Correctional Facility (10) | <input type="checkbox"/> Hospital – In-Patient Unit (31) | <input type="checkbox"/> Primary Physician Clinic (32) | <input type="checkbox"/> Specialty Physician Clinic (33) |
| <input type="checkbox"/> Home Health (05) | <input type="checkbox"/> Nursing Home/LTC (08) | <input type="checkbox"/> Psychiatric Facility (28) | |
| <input type="checkbox"/> Other (15) _____ | | | |

2b. Employment Status: (Please check only one box:)

- Employed**, defined as providing services on behalf of an entity you do not own, and receiving a W-2 Form from your employer.
 If employed, name of your employer: _____
- Self-employed**, defined as providing services as an independent contractor and paying self employment taxes using a 1099 Form.
- Incorporated**, with no employees (i.e., Inc., LLC, etc.)
 Please indicate name of business _____
- Incorporated**, with employees please call **1-888-288-3534** for more information.

- 2c. Full-time Acupuncturist (check only if total hours worked is greater than 24 hours per week)
 Part-time Acupuncturist (check only if total hours worked does not exceed 24 hours per week; eligible for 50% discount off the full-time rate)
 Student (check only if full-time student in an accredited Acupuncture program)

- 2d. Are you a medical physician or osteopathic physician? Yes No
 Do you hold any other licenses or certifications? Yes No
 If yes, please name: _____

2e. Professional education or training:

- a. Name of institution where you received your Acupuncture training: _____
 b. City _____ c. State _____ d. Date graduated ____/____/____

- e. Are you licensed or certified to perform Acupuncture? Yes No
- f. Are you credentialed by any of the following?
 NCAAOM Yes No
 ACAOM Yes No
 NOMAA Yes No
- g. Type of Certification _____
- h. Year that you began your practice of Acupuncture: _____
- 2f. Are you a member of a state Acupuncturist association? Yes No
 If yes, what state(s): _____
 Other Associations: _____ (please list)
- 2g. Are you a member of any of the following associations?
 American Council of Acupuncture (AAC) Yes No
 American Association of Acupuncture and Oriental Medicine (AAAOM) Yes No
 If yes, Current Member #: _____
- 2h. Do you use a signed patient informed consent prior to treating all patients? Yes No
- 2i. Do you have a written transfer plan for emergency situations that may occur in your office? Yes No
- 2j. Do you keep documented records (in English) of each and every treatment performed on patients, their responses, and your treatment plan? Yes No
- 2k. Are only disposable stainless steel needles used and disposed of after each use? Yes No
- 2l. Are used needles disposed of in impervious containers which are ultimately collected by a waste hauling service authorized to handle hazardous waste? Yes No
 If no, please explain: _____

I have reviewed the List of Exclusions on page 5 and certify I do not perform any of the listed treatments, procedures or therapies Yes No

C. COVERAGE INFORMATION

3. Please check the coverage limits you would like (Per Claim/Aggregate). For limits other than \$1,000,000 per claim/\$3,000,000 aggregate, please call 1-800-567-4043 for your rate.
 a. \$100,000/\$300,000 b. \$200,000/\$600,000 c. \$250,000/\$750,000 d. \$500,000/\$1,000,000
 e. **\$1,000,000/\$3,000,000**
4. Do you need Prior Acts Coverage? (If so, you must provide the Retro Date of your current policy, found on the Declarations Page. For important details on Retro Date, see "An Important Notice About Claims-Made Coverage" on page 4.)
 Yes, I need Prior Acts Coverage. My Retro Date is ____ / ____ / ____
 If requesting Prior Acts, please include a copy of your Declarations Page and a copy of your claim loss data from your current carrier.
 No, I do not need Prior Acts Coverage. I have read and understand "An Important Notice About Claims-Made Coverage" on page 4.
5. Requested Effective Date of Coverage: ____ / ____ / ____
 (Must be within 60 days from the date we receive your application. If prior to this receipt date or if not indicated, your effective date will be the receipt date.)
6. Have you ever had professional liability insurance declined, canceled or non-renewed for any reason other than for non-payment of premium? (Not applicable for MO residents)..... Yes No

7. Has any claim or lawsuit for malpractice ever been brought against you or are you aware of any incidents that may result in a claim or lawsuit? Yes No
8. Within the last 5 years, have you been the subject of complaints, charges, or disciplinary action against you for any reason, by a court, licensing board or regulatory agency responsible for maintaining the standards of your profession? Yes No
(If you have answered "yes" to questions 6, 7, or 8, please provide complete details on a separate sheet of paper and attach to application.)

Insurance Agent: Michael J. Loughran Iowa License #IA241616; Florida License #A158896

9. PROFESSIONAL LIABILITY RATES FOR A CLAIMS-MADE POLICY FORM (Limits of **\$1,000,000/\$3,000,000**)

	Year 1	Year 2	Year 3	Year 4	Mature
Full-time Professional	\$225.00	\$400.00	\$540.00	\$590.00	\$695.00
Part-time Professional	\$113.00	\$200.00	\$270.00	\$295.00	\$348.00
Student	N/A	N/A	N/A	N/A	\$150.00

- (a) **Annual premium subtotal** (see "Determining Your Rates" below) \$ _____
- (b) **General Liability subtotal** (optional, from below) \$ _____
- (c) **Total premium due** \$ _____

DETERMINING YOUR RATES

Rates for a claims-made policy increase automatically over a number of years to reflect accumulating risk, until they reach a maximum or "maturity." **If you are newly licensed or you are currently insured under an occurrence policy**, you would pay the premium listed under the "Year 1" column in the chart above. Please note this premium above on line (a) where indicated. You do not need to enter a Retro Date because it will be the same as your effective date.

If you have been insured under a claims-made policy and wish to continue your coverage without interruption you must include a copy of your current Declarations Page with this application. Please enter the Retro Date of your current policy (found on the Declarations Page), and the requested effective date of your new policy, on page 2 of this application where indicated. To determine the appropriate rate, first note the number of years that have elapsed between the dates you provided above. Fractional years of six months or more are rounded UP; less than six months rounded to the next lower year. Once you have calculated the correct number of years, add 1 to this total to represent the current year, and this number is the basis for your coverage. If the total is 5 years or more, you would pay the "Mature" rate listed on the chart above. Totals of less than 5 years pay the appropriate premium listed in the matching column. Please note this premium above on line (a) where indicated.

If you do not require Prior Acts coverage, please check the appropriate box on question 4 of this application. If you have any questions or need help with this application, or if you would like information on Prior Acts coverage for services performed before the effective date of this policy, please call 1-800-567-4043 for assistance.

OPTIONAL GENERAL LIABILITY RATES

The Professional Liability Insurance policy you are applying for includes Workplace Liability coverage. Workplace Liability is similar to general liability in that it protects your business for "non-medical" incidents that result in injury or damage. However, the limit of liability for workplace incidents is shared with your professional liability coverage limit.

The **benefit** of having general liability is that it provides a separate limit of coverage in addition to your professional liability limit and provides you with more comprehensive protection.

If leasing or renting, general liability may be required by contract with your landlord. Check any contracts you have signed for an insurance clause to make sure that you are complying with any requirements to carry a separate limit of liability. If you have any questions on general liability, please call **1-800-567-4043**.

Would you like to include the optional general liability coverage? Yes No Premium for primary practice: (a) \$150.00

Primary Practice Location: Address _____

City _____ State _____ Zipcode _____

Additional Practice Locations (please list on page 4) _____ (indicate #) x \$50.00 = (b) _____

General Liability Total due (a+b)

Total due = _____

www.hpsso.com



Acupuncturist Professional Liability Insurance Application – Claims-Made Form

(There is an additional charge for this coverage pending underwriter approval. Rate may vary due to additional location or higher limit request.)

If yes, complete the section below and attach a separate sheet if necessary.

Address	Own or Lease?
1.	
2.	
3.	

AN IMPORTANT NOTICE ABOUT CLAIMS-MADE COVERAGE – PLEASE READ

If you are currently insured under a claims-made policy, it is important that you continue your coverage without interruption when moving to a new policy. By providing HPSO with the Retroactive Date or "Retro Date" of your expiring policy, upon approval of your application, your new policy will provide you with continuous coverage. This means that any claim that might occur on or after your Retro Date will be covered under your new policy.

If you do not provide your current Retro Date on this application, and do not elect to purchase Extended Reporting Period coverage from your former insurer ("tail coverage"), your previous claims-made coverage will lapse. It will no longer respond to any claims that may arise for that original policy period – and neither will your new policy. This could leave you completely unprotected or "bare".

PAYMENT OPTIONS:

- | | |
|--|---|
| <input type="checkbox"/> Enclosed is my check. <i>(Payable to: HPSO)</i>
<input type="checkbox"/> Bill me for the annual premium. | Charge my credit card. <input type="checkbox"/> AMEX <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa
<input type="checkbox"/> Credit Card # _____ Exp. Date: ____/____ |
|--|---|

**Please add a state mandated surcharge to your annual premium.
 For NJ residents add 1.6%; for WV residents add 0.55%; for FL residents add 3.0%**

I have answered these questions to the best of my knowledge. I certify that I hold the highest credentials or standards appropriate for the healthcare profession for which I have applied as mandated by my state guidelines. I have not withheld any information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I understand that a state mandated surcharge will be added to my annual premium if I am a resident of NJ (1.6%), WV (0.55%) or FL (3.0%). I have read and consent to the compensation terms on page 5.

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only; and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: and subjects such a person to criminal or civil penalties.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

Applicant Signature X _____ Date ____ / ____ / ____

This application must be fully completed, signed and dated in ink. We will issue your certificate of insurance upon approval.

This program is underwritten by American Casualty Company of Reading, Pennsylvania, a CNA company and is offered through the Healthcare Providers Service Organization Risk Purchasing Group.

Coverages, rates and limits may differ in some states. CNA is a service mark and trade name registered with the U.S. Patent and Trademark Office.

Healthcare Providers Service Organization is a division of Affinity Insurance Services, Inc.; in NY and NH, AIS Affinity Insurance Agency; in MN and OK, AIS Affinity Insurance Agency, Inc. and in CA, AIS Affinity Insurance Agency, Inc. dba Aon Direct Insurance Administrators License #0795465.

Please see page 5 of this application for compensation disclosure information.

Acupuncturist Professional Liability Insurance Application – Claims-Made Form

(This policy does **NOT** cover the following procedures, treatments or therapies)

EXCLUSIONS

- Acupuncture as anesthesia during surgical procedures
- Chiropractic manipulation and/or adjustment
- Use of Cold Laser
- Colonic irrigations
- Dehydration of hemorrhoids
- Direct Moxibustion
- Fever therapy
- Gemstone therapy
- Use of reusable needles
- Use of Tofitness device
- Treatment of animals
- Treatment or reduction of a fracture
- X-ray, microwave and radium
- Maibotsushin/Okibari or any prolonged insertion of needles (ear tacs or seeds are acceptable)
- Obstetrics or gynecology, including delivery of babies or care of newborn infants until they are fourteen (14) days old.
- Production, promotion, solicitation, testing, selling or manufacture of vitamins, minerals, herb supplements, medicinal supplements and nutritional supplements
- Any service, treatment, advice or instruction for the purpose of skin or appearance enhancement, personal grooming, cosmetic procedures and salon or spa services including botox or its homeopathic equivalent or any fluid injection
- Treatment of cancer, epilepsy, or acquired immune deficiency syndrome, except that treatment is not excluded if such treatment is solely to alleviate pain and during the entire period of treatment, the patient is under the care of a licensed physician for the condition or disease and you do not interfere with the course of treatment recommended by such patient's treating physician.

COMPENSATION and OTHER DISCLOSURE INFORMATION

Healthcare Providers Service Organization (HPSO), a division of Affinity Insurance Services, Inc., exclusively offers the HPSO Program as an agent of CNA and provides administrative services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

As compensation for the services described above, Affinity receives 20% of your paid premium as commission for marketing the program and 20% for administrative services. In addition, Affinity receives \$0.48 annually per paid policy as commission for claim handling for the License Protection coverage extension of the professional liability insurance policy. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer and there will be no other fees or charges to you.

Your signature on your application, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as discussed above, that is to be received by Affinity.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at http://www.aon.com/market_relationships for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interests.

Contracts and Agreements

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit http://www.aon.com/market_relationships for more detail on these agreements.

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty **Review Status:** Approved 03/19/2008

Comments:

Attachment:

industry_rates_PCtransDoc_intelligent forms.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: New Business Renewal Business f. State Filing #: g. SERFF Filing #: h. Subject Codes
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3. Group Name	Group NAIC #

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #

5. Company Tracking Number	
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail

7. Signature of authorized filer	
8. Please print name of authorized filer	

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	
10. Sub-Type of Insurance (Sub-TOI)	
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: _____ Renewal: _____
15. Reference Filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	
19. Status of filing in domicile	<input type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

***Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

PC TD-1 pg 2 of 2

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	
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2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	
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3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	
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2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	
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Rate Increase
 Rate Decrease
 Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)	
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4a.	Rate Change by Company (As Proposed)						
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)

4b.	Rate Change by Company (As Accepted) For State Use Only						
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)			
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		COMPANY USE	STATE USE
5a	Overall percentage rate indication (when applicable)		
5b	Overall percentage rate impact for this filing		
5c	Effect of Rate Filing – Written premium change for this program		
5d	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	
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7.	Effective Date of last rate revision	
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8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	
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9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
02		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
03		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	