ADMIRAL INSURANCE COMPANY

a W. R. Berkley Company

CHIROPRACTOR SUPPLEMENT
FOR PROFESSIONAL LIABILITY COVERAGE (CLAIMS MADE BASIS)
(TO BE SUBMITTED WITH THE ADMIRAL PHYSICIANS AND SURGEONS APPLICATION)

1. Name of Applicant: ____

   Address: ____

   Street City/State Zip

2. Does the applicant perform any of the following services (if so, please provide proof of training):
   a. Manipulation Under Anesthesia _______ % of patient population
   b. Prenatal Care _______ % of patient population
   c. Platelet-Rich Plasma _______ % of patient population
   d. Stem Cell Injections* _______ % of patient population

   *Please also provide information on the product and what the stem cell injections are being used to treat.

3. Does the applicant require coverage for an entity? If so, please provide the following:
   a. Name of Entity: ______________________________________
   b. Ownership Structure
   c. Please provide a breakdown by staff
   d. Please Include COI's evidencing equal PL limits for any chiropractor, physician or naturopath that works on behalf of the entity (if it is an owned entity)

4. Please provide the following:
   a. Currently signed and dated Admiral Physicians and Surgeons Application
   b. 5 years currently valued carrier loss runs
   c. Currently signed and dated Admiral Claims Supplement

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations made in this application. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Electronic Signature of Applicant of Authorized Representative:

Current Date:

Title:

<u>If you prefer not to return Application with an electronic signature, please print and sign below.</u>