

- o DEERFIELD INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
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ALTERNATIVE THERAPIES SUPPLEMENT

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

1. APPLICANT PROFESSIONAL SERVICES & MEDICAL PRACTICE

- | | |
|---|---|
| <p>a) Acupuncture, for analgesia, asthma, nicotine addiction, headache, low back pain (circle each that apply)... [] Yes [] No
 If yes, do you <u>only</u> 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.)</p> <p>b) Electro acupuncture..... [] Yes [] No</p> <p>c) Acupressure [] Yes [] No</p> <p>d) Ayurvedic Medicine [] Yes [] No</p> <p>e) Biofeedback..... [] Yes [] No</p> <p>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 ____/____/____.</p> <p>g) Chiropractic [] Yes [] No
 If yes, do you perform manipulation under anesthesia? [] Yes [] No</p> <p>h) Homeopathy [] Yes [] No</p> <p>i) Hypnosis [] Yes [] No</p> <p>j) Invasive Procedures (If yes, attach details.) [] Yes [] No</p> <p>k) Light Therapy..... [] Yes [] No</p> | <p>l) Massage Therapy..... [] Yes [] No</p> <p>m) Megavitamins [] Yes [] No
 If yes, do you sell these products? [] Yes [] No
 (If yes, attach details.)</p> <p>n) Moxibustion, direct [] Yes [] No</p> <p>o) Naturopathy..... [] Yes [] No</p> <p>p) Nutritional Supplements [] Yes [] No
 If yes, do you sell these products? .. [] Yes [] No
 (If yes, attach details.)</p> <p>q) Osteopathy..... [] Yes [] No</p> <p>r) Pharmacological & Biological Treatments [] Yes [] No
 If Chelation Therapy, refer to Item (f.)
 (If Others, attach details.)</p> <p>s) Reflexology [] Yes [] No</p> <p>t) Reiki [] Yes [] No</p> <p>u) Therapeutic Touch [] Yes [] No</p> <p>v) Traditional Chinese Medicine [] Yes [] No</p> <p>w) Western Herbalism..... [] Yes [] No
 If yes, do you sell these products? .. [] Yes [] No
 (If yes, attach details.)</p> <p>x) Other (If yes, attach details.) [] Yes [] No</p> |
|---|---|

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.