Allied Ayurvedic Council

APPLICATION FOR MEMBERSHIP AND COVERAGE

Contact Information

Full Name (First, Middle, Last) _____ Practice / Clinic Name _____

Primary Practice / Office Address (Include Suite #) _____ City _____ State _____ Zip _____

Mailing Address – If Different from Practice Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____ Office Phone _____ Fax _____

Practice Background

1. List any current Ayurveda certification you hold (attach a copy or additional sheets if needed):

   Certification Number: _____ Completed (Mo/Yr): ____/____ Hrs. of Training: _____

   Certification Number: _____ Completed (Mo/Yr): ____/____ Hrs. of Training: _____

2. List other health licenses/ certifications you hold: ❒ None ❒ RN ❒ LMT ❒ Nutrition ❒ Other _____

3. Do you understand and agree that your Ayurveda practice must only address a person's general well-being through a program of Nutrition, Lifestyle Recommendations, Yoga and Meditation, and when applicable and permitted by state law, Massage / Bodywork, and may not involve treating any condition, disease or injury? (*If NO, explain*) ❒ Yes ❒ No

4. Do you intend to provide massage as part of your practice? ❒ Yes ❒ No
   If YES, a separate Massage application is required. Please request.

5. Please indicate who you were referred by: ❒ CAAM ❒ Other _____

Claims and Other History

*(If you answer **Yes** to any of the following, attach a detailed explanation including status, dates, and outcomes.)*

1. Has any malpractice claim or allegation ever been asserted against you or your associates? ❒ Yes ❒ No
2. Are you aware of any event or indication suggesting a claim may be made against you or that your care might have been deficient or caused harm? ❒ Yes ❒ No
3. Has any agency or association ever investigated or taken any action against you or your license? ❒ Yes ❒ No
4. Have you ever had malpractice insurance denied, canceled, or accepted on special terms? ❒ Yes ❒ No
5. Have you been charged with or convicted of violating any law other than a minor traffic offense? ❒ Yes ❒ No
6. Have you ever provided services to clients when your ability to perform your professional duties was compromised because of a condition, or your use of an intoxicant, medication, or other drug? ❒ Yes ❒ No

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Coverage and Payment Options

1. Limits of Liability: $1,000,000/ Occurrence $3,000,000 / Aggregate Premises Liability (slip & fall) coverage included
2. Effective Date: If approved, the date your app is received, unless you indicate a later date here: _____
3. Additional Insured: You may add an additional insured for $10 / entity. To add an Additional Insured, list below:

   _____
4. Business Personal Property (BPP) Coverage: You may add $10,000 of BPP coverage for your practice location for $101.59. To apply to a different address, provide here: _____
5. Who provides your current malpractice policy? _____ Expires: _____

Amount Due (Select Options)

Liability Coverage	Monthly (10 Pay)	Annual
☑ $1 Million/$3 Million	$ 18.00	$ 180.00

(Year 1: $180 or $18/Month. Renews at $240 or $24/Month)

Coverages Options (Annual Only - Paid at Enrollment)

☐ Additional Insureds ($10 / Entity)	
☐ Property Coverage: $10,000 Limit, Lloyd's of London: $101.59 / year	
Total Current Amount Due:	$

(If 10-Pay = 1st Month + Full amount of Coverage Options)

Select Payment (Autopay is Monthly. Options are paid at enrollment)

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express

Name on Card: _____

Card #: _____ Exp: _____

ACH Payments from: ☐ Personal Account ☐ Business Account

Account Name: _____

Account #: _____

Bank Name: _____

Bank Routing #: _____

Bank City: _____

Declaration, Acknowledgement, Authorization & Signature

Declaration: I, the applicant, represent that: 1) I am applying for membership/coverage; 2) I signed/typed my name in the place(s) provided herein; and 3) The above statements are true, and I have not misstated or suppressed any facts**.** I understand that: 1) If coverage is granted, my policy is issued in reliance upon such statements; 2) Such statements are deemed material; 3) Untrue statements could void my insurance; 4) This declaration shall be the basis of, and form a part of, my policy; 5) There is no guarantee that coverage will be renewed; and 6) The Policy requires that I report, in writing, within 3 days, or as soon as practicable, incidents reasonably likely to involve this insurance, including oral or written patient complaints, threats, or lawsuits.

Claims Made: I understand that my Policy will be limited to claims made against me during the Policy period arising out of the rendering of, or failure to render, professional services subsequent to the retroactive date. I understand that the Claims Made option provides that if the Policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the Policy was in force), unless I purchase Extended Coverage within 30 days after termination.

Authorization: If coverage is granted, I authorize you to: 1) Process payments when due, including any installments, by charging the Credit Card or debiting the Bank Account provided, in compliance with issuer agreements and U.S. law, and agree that this authority will remain in effect until I have canceled it in writing; 2) Request and receive information about me for any underwriting or claim-related inquiry from any professional association, licensing board or healthcare organization; and 3) Opt me in and allow the Company to communicate with me through Email, Fax, Phone, and SMS/ MMS messaging or other text messaging platforms.

Sign here: _____ **Date:** _____

Submit Application: **By Email**: Info@councilsupport.com **By Fax**: 714-571-1863