

# Princeton Insurance

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PARTNERSHIP. PREVENTION. PROTECTION.

## **Allied Healthcare Provider Professional Liability Application**

746 Alexander Road  
Princeton, NJ 08540-6305  
800.334.0588  
[www.PrincetonInsurance.com](http://www.PrincetonInsurance.com)

PARTNERSHIP. PREVENTION. PROTECTION.

### Section I General Information

1. Name and address of applicant

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Contact person \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_  
(Will be used to provide policyholder information only.)

Website address \_\_\_\_\_

2. Agency name and address

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_) \_\_\_\_\_

Agent's website address  
 \_\_\_\_\_

3. Birth date \_\_\_\_\_

4. Gender  Male  Female

5. Social Security # \_\_\_\_\_

### PRACTICE LOCATIONS

6. List all locations where you currently and/or anticipate working; indicate number of hours worked per week

Employer/Facility Name	Street	City	State	Zip	Employee or Independent Contractor	Total hours worked
1.						
2.						
3.						

*\*Includes patient care, hospital rounds, record keeping, administrative duties, teaching, house calls, nursing home visits, utilization review.*

7. Requested effective date \_\_\_\_\_

8. Requested retroactive date \_\_\_\_\_ **If requesting prior acts coverage, the supplemental prior acts application must be completed and a copy of your current policy must be provided.**

9. Type of coverage requested  Claims-Made  Occurrence (only available to certain classes)

10. Limits of liability requested  \$1,000,000/\$3,000,000  \$2,000,000/\$4,000,000 (only available to certain classes)

11. Do you practice as

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Optician                 | <input type="checkbox"/> Registered Nurse                                    | <input type="checkbox"/> Advanced Practice Nurse - Nurse Anesthetist                  |
| <input type="checkbox"/> Optometrist              | <input type="checkbox"/> Student Nurse                                       | <input type="checkbox"/> Advanced Practice Nurse - Clinical Nurse Specialist          |
| <input type="checkbox"/> Psychiatric Nurse        | <input type="checkbox"/> X-Ray Therapist                                     | Specialty _____   |
| <input type="checkbox"/> Physical Therapist       | <input type="checkbox"/> First Nurse Surgical Assistant                      | <input type="checkbox"/> Advanced Practice Nurse - Nurse Practitioner                 |
| <input type="checkbox"/> Psychologist             | <input type="checkbox"/> Dental Assistant/Hygienist                          | Specialty _____   |
| <input type="checkbox"/> Licensed Counselor       | <input type="checkbox"/> Social Worker                                       | <input type="checkbox"/> Pharmacist   |
| <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Physician Assistant                                 | with immunization authority? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other _____              | with surgical asst? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |

12. If you prescribe medication or medical devices, do you have a joint protocol with a collaborating physician who is licensed in NJ?  Yes  No

Applicant name \_\_\_\_\_

13. Do you prescribe controlled dangerous substances?  Yes  No  
 If yes, do you possess DEA certification and CDS registration?  Yes  No

14. List all states in which you are or have ever been licensed or certified

State	License #	Certificate #	Current Yes/No	State	License #	Certificate #	Current Yes/No

15. School of graduation \_\_\_\_\_ Degree \_\_\_\_\_ Date \_\_\_\_\_

16. Provide a detailed description of your principal activities while working

\_\_\_\_\_

\_\_\_\_\_

17. Are you an owner, operator, officer, partner or administrator or do you have a similar capacity for any health care or related services organization? If yes, please explain.  Yes  No

\_\_\_\_\_

18. Do you have a position for which no coverage is required, or for which you are insured with another carrier?  Yes  No  
 If yes, indicate activity, entity and location to be excluded and indicate hours worked at this position only \_\_\_\_\_

\_\_\_\_\_

**If you answer yes to any of questions 19 through 32, please explain on a separate sheet and provide full documentation from any agency involved.**

19. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked?  Yes  No
20. Are you currently aware of any investigation being conducted which could impact your license?  Yes  No
21. Has a complaint against you ever been submitted to the Board of Medical Examiners or are you currently under investigation by any regulatory authority?  Yes  No
22. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act?  Yes  No
23. Has your employment ever been terminated?  Yes  No
24. Do you have any condition or engage in any activity, or use any substance (including alcohol, drugs, or medications) which affects, impairs or limits your ability to practice medicine with reasonable skill and safety?  Yes  No
25. Are you in military service or employed full-time by the federal government?  Yes  No
26. Do you practice in any labor and delivery or obstetrical-related areas?  Yes  No
27. Do you provide any services over the internet?  Yes  No
28. Do you treat patients at a correctional facility?  Yes  No
29. Do you know of any circumstance, acts, errors, or omissions that could possibly result in a professional liability claim against you?  Yes  No
30. Do you anticipate any changes in staff or services provided in the next year?  Yes  No
31. Have you ever practiced without professional liability coverage?  Yes  No
32. Has your professional liability coverage ever been written with a non-admitted carrier?  Yes  No
33. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage?  Yes  No
34. Has any company ever cancelled, not renewed or refused coverage?  Yes  No

35. Name of current professional liability insurance carrier \_\_\_\_\_

Policy # \_\_\_\_\_

Type of Coverage  Occurrence  Claims-Made Expiration date \_\_\_\_\_

Applicant name \_\_\_\_\_

Loss runs from all prior carriers are required. If Claims-Made, was tail purchased?  Yes  No

36. Have any claims ever been made against you?  Yes  No

If yes, complete the following:

Plaintiff name	Incident date	Report date	Status*	Settlement amount/date	Insurance company	Description of claim

\* Open, closed without payment, closed with payment.

37. **Optional Waiver of Consent to Settle:** 1% discount to premium. If you choose this option, your coverage will be changed. An endorsement will be attached to your policy giving the company the sole right to settle any claim as it deems appropriate. Would you like this option waiver applied to your policy?  Yes  No

**CORPORATE COVERAGE** Please complete if you own a professional corporation, professional association, or limited liability corporation

38. Is coverage desired for your professional entity?  Yes  No

If yes, name of entity \_\_\_\_\_

Federal Employer Identification Number \_\_\_\_\_

39. Does your entity employ any physicians, surgeons, podiatrists, dentists, chiropractors, physician assistants, surgical assistants, residents, nurse anesthetists, nurse midwives, nurse practitioners, nurse surgical assistants, clinical nurse specialists, perfusionists, social workers or psychologists?  Yes  No

**If no, solo corporations must share the limits of liability of the individual.**

**If yes, a separate Appendix A - Staff Schedule and Appendix B - Organization Application must be completed and certificates of insurance and claims histories must be provided for each individual.**

**Section II Signature**

**This section must be completed by all applicants.**

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind Princeton Insurance Company to complete the insurance, but it is agreed that this application shall be the basis of a contract should a policy be issued. I authorize release and exchange of any underwriting or claims information between all prior carriers and Princeton Insurance Company.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Print name of applicant: \_\_\_\_\_

I understand that Princeton Insurance Company reserves the right to reject any applicant that does not meet its underwriting standards.

**NOTICE :**

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 information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

