Name: _____

Appendix B - Organization Application

1. Name of organization _____

   Address _____

   Tax ID# _____

   Effective date _____ Retroactive date _____

   Policy Type: ☐ CM ☐ OCC ☐ OP

2. a) Description of operations performed _____

   b) Description of services performed _____

	Past 12 Months	Projected Next 12 Months
Patient visits (each encounter)	_____	_____
Gross receipts	_____	_____
Payroll	_____	_____
Other	_____	_____

3. Are overnight facilities available? ☐ Yes ☐ No

4. Hours of operation _____

5. Describe the type of organization and ownership. *(Check all that apply)*

_____ Professional Association
_____ Corporation
_____ Joint Venture
_____ For Profit
_____ Other, describe _____

_____ Partnership
_____ Community Clinic (non-profit)
_____ Partnership, Limited
_____ Not for Profit

6. Are there subsidiaries that are to be included in this coverage? ☐ Yes ☐ No
   *(**If yes,** please list name of subsidiary and provide a current organizational chart)*

   _____

7. List members, shareholders, etc.

   _____

   _____

8. How long has the organization been in business? _____ Years _____ Months

9. Does the organization have a written Quality Assurance/Risk Management Program? ☐ Yes ☐ No

10. Has the organization ever been sued regardless of whether the claim was dismissed or a judgment rendered? ☐ Yes ☐ No
    *(**If yes,** please complete supplemental claims information sheet)*

11. Name of current professional liability insurance carrier _____
    (Please attach a copy of the declarations page showing: retro date, limits of liability, policy period and any restrictive endorsements)

12. Has your professional liability insurance ever been cancelled, refused or non-renewed? ☐ Yes ☐ No

13. Are procedures in place for patient transfers to another facility in the event of an emergency? ☐ Yes ☐ No
    *(**If yes,** please describe)*

    _____

    _____

    _____

    _____

Name: _____

14. Are medications administered? ☐ Yes ☐ No

    If yes, by whom?

    _____

15. Do you perform consultations, render medical services, offer medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, telemedicine or internet medicine? ☐ Yes ☐ No
    If yes, do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    If yes, provide details on a separate sheet and attach verification of coverage, if applicable.

16. **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 optional waiver applied to your policy? ☐ Yes ☐ No

Complete Appendix B for each organization named.
Attach copies of all advertising materials, stationary, telephone directory yellow pages, handouts and other advertising.

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 as well as the Company's calculation of the applicable premium should a policy be issued. As a result, I agree to inform the Company of any changes to my practice. I authorize release and exchange of any underwriting or claims information between all prior carriers and Princeton Insurance Company.

Signature:_____Date:_____

Print Name:_____