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Chiropractors Professional Liability Application

Princeton Insurance

PARTNERSHIP. PREVENTION. PROTECTION.

(800) 334-0588



Chiropractors Professional Liability Application

Section I General Information

1. Name and address of applicant

2. Agency name and address

Contact person _____

Phone (____) _____

Fax (____) _____

E-mail _____

Phone (____) _____

Fax (____) _____

E-mail _____

(Will be used to provide policyholder information only.)

Website address: _____

3. Birth date _____ 4. Gender: Male Female

5. Social Security # _____

6. License # and date for primary practice state _____

7. Type of coverage requested Claims-Made Occurrence Plus

8. Requested effective date _____ Non-binding indication only Formal Quote*

** If a formal quote is requested and it results in a declination, the declination will be reported to the Department of Insurance.*

9. 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.)**

Corporate Coverage

10. Is coverage desired for your professional corporation? Yes No

If yes, name of entity: _____

Federal Employer Identification Number: _____

11. Does your entity have any employees, independent contractors or partners? Yes No

(Employees and independent contractors are defined as 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.)

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.

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

Practice Locations

12. List all locations where you presently work. (Draw a line through any location where you are not practicing, or add additional locations):

Employer/Facility Name	Street	City	State	Zip	Employee or Independent Contractor	Total Hours worked per week*
#1						
#2						
#3						

** Includes patient care, hospital rounds, record keeping, administrative duties, teaching, house calls, nursing*

13. Name of present insurance carrier _____

Expiration date _____

Type of present policy *(Attach copy of prior policy)* Occurrence Plus (Modified Claims Made)

Occurrence Claims-Made

Loss runs from all prior carriers are required. If claims made was tail purchased? Yes No

Name: _____

14. Previous professional liability insurance carrier(s):

Company Name	Policy #	Coverage Date		Occurrence/Occurrence Plus/Claims Made	Retro. Date
		Eff.	Exp.		

15. Have you ever practiced without professional liability coverage? Yes No
16. Has your professional liability coverage ever been written with a non-admitted carrier? Yes No
17. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? Yes No
(If you answered yes to any of questions 15, 16 or 17, please provide full details on a separate sheet.)
18. If you are employed by someone else, please answer the following:
 a) Name of employer _____
 b) Name of employer's professional liability insurer _____
(If your employer is to pay the premium for your coverage, refer to Assignment of Unearned Premium form.)

Section II Practice Information

1. List all facilities or organizations where you have practiced or have had staff or courtesy privileges for your profession since graduation. *(Explain any periods of inactivity)*

Facility Name and Location	Department	Type of Privileges	Dates From/To

2. List all states in which you are licensed or have been licensed and information on that state license if applicable:

State	License #	Active Yes/No	# of Patients	% of Income	% of Office Hours

3. 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)

4. Has anyone ever filed a claim against you regardless of whether the claim was dismissed or a judgment was rendered? Yes No
(If yes, please complete a supplemental claims application for each claim)
5. Do you know of any circumstance, act, error or omission that could possibly result in a professional liability claim against you? Yes No
6. Are you in military service or employed full-time by the federal government? Yes No
7. Do you treat patients at a correctional facility? Yes No
8. Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked? Yes No
9. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked? Yes No
10. 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
11. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? Yes No

12. Has your professional liability coverage ever been cancelled, restricted, non renewed, declined or have you withdrawn an application for insurance to avoid declination? Yes No
13. Has a complaint against you ever been submitted to the Board of Chiropractic Examiners or are you currently under investigation by any regulatory authority? Yes No
14. Do you provide any services over the internet? Yes No
15. **Optional Waiver of Consent to Settle 1% discount to premium.** If you chose 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
(If you answered yes to any of questions 7 through 14, please explain on a separate sheet, and provide full documentation from any agency involved)

Section III Required Documentation

1. Claim history reports (loss runs) from all prior insurance carriers.
2. Copy of current declarations page from your current insurance carrier.
3. Copy of current New Jersey license.
4. Curriculum vitae.

Section IV Chiropractor Services

1. Indicate professional liability limits desired
 \$100,000/\$300,000 \$500,000/\$1,500,000 \$2,000,000/\$4,000,000
 \$200,000/\$600,000 \$1,000,000/\$3,000,000
2. School of Graduation: _____ Graduation Date: _____ Degree: _____
3. Date of License: _____
4. Does your practice use or involve any of the following treatments: % of practice time
- | | | | |
|---|------------------------------|---------|-----------------------------|
| a) Acupuncture or any piercing of the skin or tissue? | <input type="checkbox"/> Yes | % _____ | <input type="checkbox"/> No |
| b) Magnets or crystals to treat or diagnose? | <input type="checkbox"/> Yes | % _____ | <input type="checkbox"/> No |
| c) Performing manipulations under anesthesia (MUA)? | <input type="checkbox"/> Yes | % _____ | <input type="checkbox"/> No |
- If Yes**, is the person administering the anesthesia an MD or DO and a member of an accredited hospital? Yes No
- Name: _____
(Current certification of insurance coverage must be provided.)
- Where are the manipulations under anesthesia performed? *(Check all that apply.)*
- In hospital In office Other
- | | | | |
|---|------------------------------|---------|-----------------------------|
| d) Selling vitamins, food supplements, herbal remedies? | <input type="checkbox"/> Yes | % _____ | <input type="checkbox"/> No |
| e) Providing nutritional counseling? | <input type="checkbox"/> Yes | % _____ | <input type="checkbox"/> No |
| f) Homeopathic remedies? | <input type="checkbox"/> Yes | % _____ | <input type="checkbox"/> No |
| g) Treating animals? | <input type="checkbox"/> Yes | % _____ | <input type="checkbox"/> No |
| h) Electrodiagnostic testing using Needle EMG? | <input type="checkbox"/> Yes | % _____ | <input type="checkbox"/> No |
5. Do you offer services other than chiropractic care? Yes No
If yes, please explain.

6. List the state or municipal licensing requirements with which you currently comply to practice in your field. None required

Section V 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 the Princeton Insurance Company.

Signature of Applicant _____ Date _____
Print Name of Applicant _____

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.

Name: _____

Supplemental Claims Information

(If more than four (4) claims, please photocopy this page, complete and attach)

Please complete, in chronological order, for any closed, pending or potential claim.

1. Claimant's/plaintiff's name _____
Date care rendered _____ Date claim reported _____
Status: Open Closed Date closed _____
If closed, was any indemnity payment or award made? Yes No **If yes**, amount _____
If open, what is the amount of loss reserve or damages sought? _____
Name of insurance company defending you _____
Description of claim (include type of treatment, result of treatment, your involvement) _____

2. Claimant's/plaintiff's name _____
Date care rendered _____ Date claim reported _____
Status: Open Closed Date closed _____
If closed, was any indemnity payment or award made? Yes No **If yes**, amount _____
If open, what is the amount of loss reserve or damages sought? _____
Name of insurance company defending you _____
Description of claim (include type of treatment, result of treatment, your involvement) _____

3. Claimant's/plaintiff's name _____
Date care rendered _____ Date claim reported _____
Status: Open Closed Date closed _____
If closed, was any indemnity payment or award made? Yes No **If yes**, amount _____
If open, what is the amount of loss reserve or damages sought? _____
Name of insurance company defending you _____
Description of claim (include type of treatment, result of treatment, your involvement) _____

4. Claimant's/plaintiff's name _____
Date care rendered _____ Date claim reported _____
Status: Open Closed Date closed _____
If closed, was any indemnity payment or award made? Yes No **If yes**, amount _____
If open, what is the amount of loss reserve or damages sought? _____
Name of insurance company defending you _____
Description of claim (include type of treatment, result of treatment, your involvement) _____

Assignment of Unearned Premium

- 1. If the premium payer is other than the named insured, is this unearned premium assigned to the payer?
 - Yes. *Complete remainder of agreement; include both parties' signatures.*
 - No.

Agreement to Assign Unearned Premium

- 2. _____, hereinafter referred to as the Corporation and _____, referred to as the Medical Care Practitioner (MCP), hereby enter into this agreement.
 - a) Whereas the Corporation has agreed with the MCP to pay the cost of professional liability coverage for the MCP during the current policy term beginning _____ and may do so for subsequent renewals, and;
 - b) Whereas the premiums for professional liability insurance coverage for the MCP may be due and payable in advance for the policy period.

Now, therefore, the parties hereto agree to the following:

In consideration for the Corporation paying the premiums for said insurance, the MCP hereby:

- 1. Assigns and gives a security interest to the Corporation for any and all unearned premiums which may become payable from the professional liability policy paid for by the Corporation.
- 2. Irrevocably appoints the Corporation as the MCP's Attorney-In-Fact with full authority to cancel the MCP's professional liability policy purchased by the Corporation, receive all sums assigned to the Corporation or in which the MCP has granted the Corporation a security interest in furtherance of this agreement.
- 3. All legal rights given to the Corporation shall benefit the Corporation's successors and assigns and shall remain in effect until the MCP provides written notification of termination to both the Corporation and insurance company which issued the policy.
- 4. The MCP agrees not to further assign any interest in said professional liability policy without the Corporation's written consent.

Date _____

Date _____

Medical Care Practitioner Signature _____

Corporation _____

Print Name of Applicant _____

Officer _____

Home Address* _____

Address of Corporation _____

City, State, Zip* _____ Home Phone Number* _____

Witness to Medical Care Practitioner's signature _____

****This information will only be used for cancellation notification and Extended Reporting offers only.***

Appendix A - Staff Schedule

Policy Number: _____

Corporation Name: _____

Do you anticipate any changes in staff or services provided by this entity in the next year? Yes No

If yes, please describe: _____

List all professional staff including members, partners and shareholders (Physicians, Chiropractors, Dentists, etc.)

Name	Policy # if Princeton insured	License number	Specialty or position	Date of hire	Status		Avg. # hrs. per wk
					Employee	Independent Contactor	

List all Allied Professionals (RN, LPN, CRNA, Nurse Midwife, Techs, Social Worker, Occupational or Physical Therapist, Licensed Counselor, Physician Assist Non-Surg. or Surg., etc.)

Name	Policy # if Princeton insured	License number	Specialty or position	Date of hire	Status		Avg. # hrs. per wk
					Employee	Independent Contactor	

List all other clerical staff

Name	Position	Date of hire	Avg. # hrs. per wk.

For all professional staff not insured with Princeton, attach certificates of insurance or a copy of their professional liability policy and claims history for each individual.

Signature: _____ Date: _____

Name: _____

Appendix B - Organization Application

1. Name of organization _____
Address _____
Tax ID# _____
Retroactive date _____

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 on 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)

14. Are medications administered? Yes No
If yes, by whom?

15. **Optional Waiver of Consent to Settle 1% discount to premium.** If you chose 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.