

# Princeton Insurance

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PARTNERSHIP. PREVENTION. PROTECTION.

## Chiropractor

## Professional Liability Application

746 Alexander Road  
Princeton, NJ 08540-6305  
(800) 334-0588  
[www.PrincetonInsurance.com](http://www.PrincetonInsurance.com)

### 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 \_\_\_\_\_
2. Agency name and address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_) \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Website \_\_\_\_\_
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 results in an 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.**

### Practice Locations

10. List all locations where you currently and/or anticipate working; indicate the 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, recordkeeping, administrative duties, teaching, house calls, nursing home visits, utilization review.

11. 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

12. Previous professional liability insurance carrier(s)

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

**If you answer yes to any of questions 13, 14, or 15, please provide full details on a separate sheet.**

13. Have you ever practiced without professional liability coverage?  Yes  No
14. Has your professional liability coverage ever been written with a non-admitted carrier?  Yes  No
15. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage?  Yes  No

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

16. If you are employed by someone else, please complete 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 our 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

4. Has anyone ever filed a claim against you regardless of whether the claim was dismissed or a judgment was rendered? If yes, please complete a supplemental claims application for each claim.  Yes  No

**If you answer yes to any of questions 5 through 15, please explain on a separate sheet and provide full documentation from any agency involved.**

- 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. Do you anticipate any changes in staff or services provided in the next year?  Yes  No
- 7. Are you in military service or employed full-time by the federal government?  Yes  No
- 8. Do you treat patients at a correctional facility?  Yes  No
- 9. Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked?  Yes  No
- 10. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered, or has probation been invoked?  Yes  No
- 11. 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
- 12. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act?  Yes  No
- 13. 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
- 14. Has a complaint against you ever been submitted to the New Jersey State Board of Chiropractic Examiners or are you currently under investigation by any regulatory authority?  Yes  No
- 15. Do you provide any services over the internet?  Yes  No

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

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

**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     \$1,000,000/\$3,000,000     \$2,000,000/\$4,000,000
  
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) Selling vitamins, food supplements, herbal remedies?	<input type="checkbox"/> Yes	% _____	<input type="checkbox"/> No
d) Providing nutritional counseling?	<input type="checkbox"/> Yes	% _____	<input type="checkbox"/> No
e) Homeopathic remedies?	<input type="checkbox"/> Yes	% _____	<input type="checkbox"/> No
f) Treating animals?	<input type="checkbox"/> Yes	% _____	<input type="checkbox"/> No
g) Electrodiagnostic testing using needle EMG?	<input type="checkbox"/> Yes	% _____	<input type="checkbox"/> No
h) Performing manipulations under anesthesia (MUA)?	<input type="checkbox"/> Yes	% _____	<input type="checkbox"/> No

If yes, is the person administering the anesthesia an MD or OD 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
  
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

**Corporate Coverage Please complete if you own a professional corporation, professional association, or limited liability corporation**

1. Is coverage desired for your professional entity?  Yes  No  
 If yes, name of entity \_\_\_\_\_  
 Federal Employer Identification Number \_\_\_\_\_

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

2. 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 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 V Signature**

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 \_\_\_\_\_

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.

**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 the unearned premium assigned to the payer?
  - Yes Complete remainder of agreement and 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 signature

\_\_\_\_\_  
Home address\*

\_\_\_\_\_  
Print officer name

\_\_\_\_\_  
City, State, Zip\*

\_\_\_\_\_  
Address of corporation

\_\_\_\_\_  
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**

Entity Name \_\_\_\_\_

List all owners, partners, independent contractors, and employees (physicians, chiropractors, dentists, etc.)

Name	Policy #, if Princeton Insured	License Number	Specialty or Position	Date of Hire	Avg # of Hrs Per Week

List all allied professionals (RN, LPN, CRNA, Nurse Midwife, Tech, Medical Assistant, Social Worker, Occupational or Physical Therapist, Licensed Counselor, Physician Assistant-Surgery or Non-Surgery, etc.)

Name	Policy #, if Princeton Insured	License Number	Specialty or Position	Date of Hire	Avg # of Hrs Per Week

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 \_\_\_\_\_

**Appendix B - Organization Application**

1. Name of entity \_\_\_\_\_  
 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 entity and ownership (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Professional Association | <input type="checkbox"/> Partnership                   |
| <input type="checkbox"/> Corporation              | <input type="checkbox"/> Community Clinic (non-profit) |
| <input type="checkbox"/> Joint Venture            | <input type="checkbox"/> Partnership, Limited          |
| <input type="checkbox"/> For Profit               | <input type="checkbox"/> Not for Profit                |
| <input type="checkbox"/> Other, describe _____    |  |
| _____   |  |
| _____   |  |
| _____   |  |

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 entity been in business? \_\_\_\_\_ Years \_\_\_\_\_ Months

9. Does the entity have a written quality assurance/risk management program?  Yes  No

10. Has the entity 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 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.**