



## **Physician & Surgeon Professional Liability Application**

# Physician and Surgeon Professional Liability Application

## Section I General Information

1. Name and mailing 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 (\_\_\_\_) \_\_\_\_\_

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  Occurrence

8. Indicate professional liability limits desired

\$1,000,000/\$3,000,000  \$2,000,000/\$4,000,000 (If higher limits are desired, please refer to company.)

9. Requested effective date \_\_\_\_\_  Non-binding indication only  Formal quote\*

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

10. Requested retroactive date \_\_\_\_\_ If requesting prior acts coverage – coverage for your practice before the effective date listed in response to #9 above – the supplemental prior acts application must be completed and a copy of your current policy must be provided.

### Practice Locations

11. List all locations where you will be working for which you are applying for this insurance coverage.

Employer/Facility Name	Address	Employee or Independent Contractor	Total Hours Worked per week*
1.			
2.			
3.			

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

12. Please indicate (if applicable) total hours worked per week and month at each location for the following activities:

- A. Actual patient care, including recordkeeping and hospital rounds
- B. Administrative duties
- C. Surgeries and assists
- D. House calls and nursing home visits
- E. Utilization review
- F. Teaching

Loc. #1		Loc. #2		Loc. #3	
WK	MO	WK	MO	WK	MO
<b>Total hours worked per week/month</b>					

**Total hours worked per week/month**

13. List all locations where you will be working for which you have other coverage and are not applying for this insurance.

Employer/Facility Name	Address	Employee or Independent Contractor	Name of Ins Carrier Providing Coverage
1.			
2.			
3.			

14. Name of present insurance carrier \_\_\_\_\_  
 Expiration date \_\_\_\_\_  
 Type of present policy (Attach copy of policy)  Occurrence Plus (Modified Claims-Made)  
 Occurrence  Claims-Made- If claims-made, was tail purchased?  Yes  No

**Loss runs from all prior carriers are required.**

15. Previous professional liability insurance carrier(s)

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

16. If you are employed by someone else, please answer the following  
 a) Name of employer \_\_\_\_\_  
 b) Name of employer's professional liability carrier \_\_\_\_\_  
*(If your employer is to pay the premium for your coverage, the Assignment of Unearned Premium Form must be completed.)*

**If you answer yes to questions 17, 18, 19 or 20, please provide full details on a separate sheet.**

17. Have you ever practiced without professional liability coverage?  Yes  No
18. Has your professional liability coverage ever been written with a non-admitted carrier?  Yes  No
19. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage?  Yes  No
20. Do you know of any circumstance, act, error or omission that could possibly result in a professional liability claim against you?  Yes  No
21. 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

**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. Do you admit patients to any of the above hospital(s)?  Yes  No  
*If no, please explain your protocol to admit patients to a hospital, if the circumstances would arise, on a separate sheet.*

Applicant Name \_\_\_\_\_

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

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

4. Are you entering private practice for the first time?  Yes  No

5. Please explain the following gaps if they occurred in the last ten (10) years:

(a) Gaps greater than one (1) year between your medical school, residency, other training or first time in practice.

(b) Gaps greater than six (6) months between practice locations.

6. To which medical societies or associations do you belong? \_\_\_\_\_

7. Do you treat patients at a correctional facility?  Yes  No

*If yes, (a) average hours per week devoted to treating or reviewing treatment of federal prison inmates: \_\_\_\_\_ hrs*

*(b) average hours per week devoted to treating or reviewing treatment of non-federal prison inmates: \_\_\_\_\_ hrs*

8. Are you a team physician for any professional or collegiate athletes?  Yes  No

*If yes, indicate the percentage of your practice devoted to this activity: \_\_\_\_\_%*

9. Do you practice in a nursing home facility?  Yes  No

*If yes, indicate the percentage of your practice devoted to this activity: \_\_\_\_\_%*

10. Do you practice as a Medical Director?  Yes  No

*If yes, what percentage of your practice is devoted to this activity: \_\_\_\_\_%*

Type and Name of Facility: \_\_\_\_\_

11. Do you devise or review plant/employer safety standards?  Yes  No

*If yes, what products are manufactured by the company? \_\_\_\_\_*

Company name and location: \_\_\_\_\_

**If you answer yes to any of questions 13 through 22 please explain on a separate sheet, and provide full documentation from any agency involved.**

12. Indicate the number of each of the following who provide services in your office (please exclude yourself):

- |                     |                                 |                                     |
|---------------------|---------------------------------|-------------------------------------|
| Physicians _____    | Nurse Midwives _____            | Physician Assistants _____          |
| Dentists _____      | Nurse Midwife Assistants _____  | Physician Surgical Assistants _____ |
| Aestheticians _____ | Nurse Practitioners _____       | Podiatrists _____                   |
| Case Managers _____ | Nurse Surgical Assistants _____ | Psychologists _____                 |
| CRNAs/RNAs _____    | Occupational Therapists _____   | Respiratory Therapists _____        |
| Chiropractors _____ | Perfusionists _____             |                                     |

13. Do you or any member of your practice supervise any healthcare provider that you do not employ or contract with for services?  Yes  No

14. Are you in military service or employed full-time by the federal government?  Yes  No

15. Do you anticipate any changes in staff or services provided in the next year?  Yes  No

16. Has any healthcare facility ever denied, restricted, suspended or revoked privileges or has probation been invoked?  Yes  No

17. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked?  Yes  No

18. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (i.e., convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc).  Yes  No  
*If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.*

Type(s) of Illness: \_\_\_\_\_

Date(s) of Treatment: From \_\_\_\_\_ to \_\_\_\_\_  Currently in Treatment

Name of Treating Physician(s): \_\_\_\_\_

Address(es): \_\_\_\_\_

19. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act?  Yes  No
20. Have you ever been accused of sexual misconduct of any kind?  Yes  No
21. Has your professional liability coverage ever been cancelled, restricted, non renewed, declined, or have you withdrawn an application for insurance to avoid declination, or have you ever had an involuntary deductible or surcharge assessed against your policy?  Yes  No
22. 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
23. Do you participate as a principal investigator for any clinical trials?  
*If yes, do you follow FDA-approved protocols?*  Yes  No  
 Yes  No
24. **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 Physician/Surgeon Services**

1. Please indicate the applicable percentage of your practice (total should equal 100%).

\_\_\_\_\_ % MAJOR SURGERY – performing major surgery including all procedures performed using general anesthesia.  
 \_\_\_\_\_ % Obstetrics: Number of deliveries per year \_\_\_\_\_  
 \_\_\_\_\_ % Pregnancy terminations:  
 \_\_\_\_\_ % first trimester terminations, \_\_\_\_\_ % second trimester terminations

\_\_\_\_\_ % ASSISTING IN MAJOR SURGERY  
 If you assist in major surgery, do you provide post-operative follow-up care?  Yes  No

\_\_\_\_\_ % MINOR SURGERY - performing minor surgery  
**(Use of general anesthesia for any procedure constitutes major surgery)**

\_\_\_\_\_ % NO SURGERY - medical practice which may include incising boils and abscesses, removal of superficial skin lesions, suturing minor lacerations.

2. Specialty you currently practice \_\_\_\_\_
3. Are you permanently retired from the practice of clinical medicine?  Yes  No
4. List procedures you perform that are not typical to the specialty in which you received your residency or fellowship training  none

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. List any procedures you perform in the office setting for which you are not privileged to perform in a hospital  none

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Have there been any changes in your specialty, classification, or practice activity within the past ten years?  Yes  No  
 Have you discontinued performing minor or major surgical procedures within the past ten years?  Yes  No  
*If yes, list procedures/activities, reason for and date of change(s) on a separate sheet.*
7. Have you performed weight control surgery or prescribed weight control medication within the past ten years?  Yes  No  
 Do you have ownership or financial interests in a weight control clinic?  Yes  No
8. Do you work in an emergency room on a scheduled basis?  Yes  No  
*If yes: (a) indicate average number of hours per month devoted to in-hospital emergency room care (not on-call hours) \_\_\_\_\_  
 (b) on average how many of the above hours are you working in order to fulfill staff privilege requirements? \_\_\_\_\_*
9. Do you perform consultations, render medical services, 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.*
10. Are you board certified by an AMA-approved specialty board?  Yes  No  
 Name of specialty board \_\_\_\_\_ Date of last certification \_\_\_\_\_  
 If no, are you board qualified?  Yes  No  
 If not board qualified, provide explanation on a separate sheet.
11. Have you ever failed any licensing or board certification or recertification examination?  Yes  No  
*If yes, please provide name(s) of exam(s) and number of times failed on a separate sheet.*
12. Medical school \_\_\_\_\_ Date of graduation \_\_\_\_\_
13. If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates?  Yes  No
14. Are you currently an intern, resident or fellow?  Yes  No  
*If yes, what will be the final date of internship, residency or fellowship? \_\_\_\_\_*
15. Where did you serve  
 Internship \_\_\_\_\_ Date of completion \_\_\_\_\_  
 Residency \_\_\_\_\_ Specialty \_\_\_\_\_ Date of completion \_\_\_\_\_  
 Fellowship \_\_\_\_\_ Specialty \_\_\_\_\_ Date of Completion \_\_\_\_\_

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**16. Please check any of the following procedures you will perform:**

- Abdominoplasty - Tummy Tuck
- Abortions - Elective \_\_\_\_\_% of total practice
- Abortions - Therapeutic \_\_\_\_\_% of total practice
- Acupuncture -Therapeutic/Local Anesthetic
- Anesthesia – General/Spinal/Caudal
- Angiography
- Angioplasty
- Arteriography
- Arthroscopy
- Assist in major surgery - own patients only
- Assist in major surgery - own & other than own patients
- Bariatric surgery - Laproscopic
- Bariatric surgery - Non-Laproscopic
- Biopsy - Endoscopic
- Blepharopigmentation \_\_\_\_\_% of total practice
- Blepharoplasty - Cosmetic \_\_\_\_\_% of total practice
- Blepharoplasty - Reconstruction \_\_\_\_\_% of total practice
- Botox \_\_\_\_\_% of total practice
- Brachioplasty
- Breast Implants - Cosmetic \_\_\_\_\_% of total practice
- Breast Implants - Reconstruction \_\_\_\_\_% of total practice
- Breast Reduction - Cosmetic
- Bronchoscopy
- Broncho-esophagology
- Buttock Implants
- Calf Implants
- Cataract Surgery
- Catheterization - Left Heart
- Catheterization - Right Heart (other than CVP lines)/Swan Ganz
- Cheek/Chin/Lip Implants
- Chelation therapy
- Chemical Peels - Superficial/Medium
- Chemical Peels - Deep \_\_\_\_\_% of total practice

- Cleft Lip Surgery - Reconstructive
- Cleft Palate Surgery - Reconstructive
- Colonoscopy
- Cryosurgery (*Cervical*)
- Cryosurgery (*non-external lesions*)
- D&C
- Discectomy
  - Open
  - Other Than Open
- Electromagnetic Therapy
- Electroconvulsive/Shock Therapy
- Embolization
- ERCP
- Face lifts
- Face lifts Mini (*done with laser*)\_\_\_\_\_% of total practice
- Gastrointestinal Endoscopy
- Gynecology - Major Surgery
- Hair Transplants - Follicular Unit Transplantations
- Hair Transplants - Other
- HVLA on the cervical spine on patients younger than 18 years of age
- Intrathecal Pumps
- Kyphoplasty
- Laparoscopic Cholecystectomy
- Laparoscopy
- Laser surgery
- Laser Therapy (*Endoscopic*)
- Laser Therapy (*Non-Endoscopic*)
- Lipoinjection \_\_\_\_\_% of total practice
- Liposuction
  - Other Than Tumescent Technique
  - Tumescent Technique Only \_\_\_\_\_% of total practice
- Lithotripsy
- Lymphangiography
- Mammograms
- Myelography
- Nerve Blocks
  - Facet
  - Lumbar Epidural Steroid
  - Myofascial
  - Occipital
  - Paraspinal/Paravertebral

- Peripheral
- Sciatic
- Triggerpoint Injection
- Oxidation Therapy
- Pacemakers - Epicardial
- Pacemakers - Endocardial
- Pacemakers - Temporary
- Peritonoscopy
- Phlebography
- Pneumoencephalography
- Polypectomy
- Prenatal/Gynecological Practice
  - Prenatal Practice - 1st & 2nd Trimester
  - Prenatal Practice - to term, no delivery
  - Prenatal Practice - to term and delivery
  - Normal Deliveries - total per year \_\_\_\_\_
  - Cesarean Deliveries - total per year \_\_\_\_\_
- Prolotherapy
- Radial/Laser Keratotomy
- Radiation/X-Ray Therapy
- Rectal Ozone Therapy
- Rhinoplasty \_\_\_\_\_% of total practice
- Sigmoidoscopy - 60 cm or less
- Sigmoidoscopy - Greater than 60 cm
- Silicone Injections \_\_\_\_\_% of total practice
- Skin Flaps/Grafts
  - Cosmetic \_\_\_\_\_% of total practice
  - Reconstruction \_\_\_\_\_% of total practice
- Spinal Cord Stimulators
- Thigh Lift
- Tubal Ligations
- Upper GI Endoscopy
- Vaginal Rejuvenation Procedures (*for cosmetic or sexual enhancement*)
- Vasectomies - own patients
- Vasectomies - own & other than your own patients
- Weight Control Medication \_\_\_\_\_% of total practice
- Other Medical Techniques

List Procedures (*do not restate your specialty*)

\_\_\_\_\_

\_\_\_\_\_

**17. Please indicate the percentage of your total practice performing the following activities:**

- |   |  |   |
|---|--|---|
| _____ % Cardiac                         | _____ % Obstetrics                                   | _____ % Thoracic                          |
| _____ % Gynecology                      | _____ % Ophthalmology)                               | _____ % Traumatic                         |
| _____ % Hand                            | _____ % Orthopedic ( <i>including back</i> )         | _____ % Urology                           |
| _____ % Independent Medical Exams (IME) | _____ % Orthopedic ( <i>not including back</i> )     | _____ % Vascular                          |
| _____ % Neurosurgery                    | _____ % Otolaryngology                               | _____ % Other Medical ( <i>describe</i> ) |
|   | _____ % Plastic ( <i>cosmetic enhancement only</i> ) | _____                                     |
|   | _____ % Plastic ( <i>reconstruction only</i> )       | _____                                     |

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

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

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

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

19. Does your entity have any employees, independent contractors or partners that are:  Yes  No

- Aestheticians                       Nurse Anesthetists                       Occupational Therapists    Psychologists    Surgical Assistants
- Case Managers                       Nurse Midwives                       Podiatrists                       Residents
- Chiropractors                       Nurse Midwife Assistants                       Perfusionists                       Respiratory Therapists
- Clinical Nurse Specialists    Nurse Practitioners                       Physicians                       Social Workers
- Dentists                       Nurse Surgical Assistants    Physician Assistants                       Surgeons

**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**

ANY PERSON WHO KNOWINGLY FILES AN APPLICATION FOR INSURANCE OR A 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 ALSO PUNISHABLE BY CRIMINAL AND/OR CIVIL PENALTIES IN CERTAIN JURISDICTIONS.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree to notify the Princeton Insurance Company (hereafter "Princeton") if there are any future material changes in any answer to this application, or its attachments, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide Princeton the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will extend to me or that a policy of insurance will be issued.

I understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit – based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit – based insurance score.

I further understand and agree that I have no right to demand or expect coverage until Princeton has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if Princeton has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or the first installment by check, electronic transfer or money order, it shall not be considered as "received" by Princeton until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that Princeton may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to Princeton any information regarding me, which Princeton, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

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.**



**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 name of officer

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

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

(\_\_\_\_\_) \_\_\_\_\_  
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**

Entity name \_\_\_\_\_

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

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

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

Name	Policy #, if Princeton Insured	License #	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: \_\_\_\_\_

Name: \_\_\_\_\_

**Appendix B - Organization Application**

1. Name of organization \_\_\_\_\_  
Address \_\_\_\_\_  
Tax ID# \_\_\_\_\_  
Effective date \_\_\_\_\_ Retroactive date \_\_\_\_\_  
Policy Type:  Claims-Made  Occurrence  Occurrence Plus

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
- Partnership
- Corporation
- Community Clinic (non-profit)
- Joint Venture
- Partnership, Limited
- For Profit
- Not for Profit
- 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 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?

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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.**

ANY PERSON WHO KNOWINGLY FILES AN APPLICATION FOR INSURANCE OR A 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 ALSO PUNISHABLE BY CRIMINAL AND/OR CIVIL PENALTIES IN CERTAIN JURISDICTIONS.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree to notify the Princeton Insurance Company (hereafter "Princeton") if there are any future material changes in any answer to this application, or its attachments, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide Princeton the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will extend to me or that a policy of insurance will be issued.

I understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit – based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit – based insurance score.

I further understand and agree that I have no right to demand or expect coverage until Princeton has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if Princeton has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or the first installment by check, electronic transfer or money order, it shall not be considered as "received" by Princeton until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that Princeton may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to Princeton any information regarding me, which Princeton, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_