



Allied Healthcare Provider Renewal Application

COMPLETED RENEWAL APPLICATION REQUIRED FOR RENEWAL OF YOUR POLICY
 (Please indicate any corrections or changes you wish to make.)

Policy Number: _____ Policy Effective Date: _____

1. Agency name and address: _____

Phone: _____ Fax: _____ E-mail: _____

2. Name and mailing address of insured:

 Phone: _____
 Fax: _____
 E-mail: _____
(Will be used to provide policyholder information only.)
 Website: _____

3. School of graduation: _____ Date of graduation: _____

4. Birthdate: _____ 5. Gender: Male Female

6. License # for primary practice state: _____

Corporate Coverage

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

If yes, name of entity: _____

Federal Employer Identification Number: _____

8. 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

9. 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 home visits, utilization review.

10. Do you practice as:

- Graduate Nurse
- Licensed Practical Nurse
- Nurse Anesthetist
- Nurse Midwife
- Nurse Practitioner
- Specialty _____
- Clinical Nurse Specialist
- Psychologist

- Optician
- Optometrist
- Pharmacist
- Physical Therapist
- Physician's Assistant
- (with Surgical Assist?) Yes No
- Psychiatric Nurse
- Other _____

- Registered Nurse
- Student Nurse
- X-Ray Therapist
- First Nurse Surgical Assistant
- Dental Assistant/Hygienist
- Licensed Counselor
- Social Worker

11. **CLAIMS UPDATE - IMPORTANT - Your premium will be affected by this information.**

- Other than with Princeton, have any new claims been made against you? Yes No
- Have any previously open claims been closed without indemnity payment? Yes No
- Have any previously open claims been closed with indemnity payment? Yes No
- _____ Amount

If you answered "Yes" to any of the above claims questions, you must provide copies of updated loss runs from your prior carrier.

12. 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: _____

13. Do you provide any services over the Internet? Yes No

If yes, please explain: _____

14. Do you know of any circumstance, act, error or omission that could possibly result in a professional liability claim against you? Yes No

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

16. Has any healthcare facility ever denied, 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. 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

19. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? Yes No

20. 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

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

22. Do you practice in any labor and delivery or obstetrical-related areas? Yes No

(If you answered yes to any of questions 14 through 22, please explain on a separate sheet, and provide full documentation from any agency involved)

23. **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

This section must be signed by all insureds:

All of the above information is true to the best of my knowledge and belief. It is agreed that this application shall be the basis of a contract for a policy issued by Princeton Insurance Company. I authorize the release and exchange of any underwriting or claims information between all prior carriers and the Princeton Insurance Company.

Signature of Insured: _____ Date: _____

Print Name of Insured: _____ Policy Number: _____

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

NOTICE TO NEW JERSEY APPLICANTS:

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, concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.