

PARTNERSHIP. PREVENTION. PROTECTION.

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 \_\_\_\_\_

2. Name and mailing address of insured \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

(will be used to provide policyholder information only.)

Website \_\_\_\_\_

3. Birthdate \_\_\_\_\_

4. License # for primary practice state \_\_\_\_\_

### PRACTICE LOCATIONS

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

6. Do you practice as

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Optician                 | <input type="checkbox"/> Registered Nurse                                      | <input type="checkbox"/> Advanced Practice Nurse - Nurse Anesthetist                            |
| <input type="checkbox"/> Optometrist              | <input type="checkbox"/> Student Nurse   | <input type="checkbox"/> Advanced Practice Nurse - Nurse Midwife                                |
| <input type="checkbox"/> Psychiatric Nurse        | <input type="checkbox"/> X-Ray Therapist                                       | <input type="checkbox"/> Advanced Practice Nurse - Clinical Nurse Specialist<br>Specialty _____ |
| <input type="checkbox"/> Physical Therapist       | <input type="checkbox"/> First Nurse Surgical Assistant                        | <input type="checkbox"/> Advanced Practice Nurse - Nurse Practitioner<br>Specialty _____        |
| <input type="checkbox"/> Psychologist             | <input type="checkbox"/> Dental Assistant/Hygienist                            | <input type="checkbox"/> Pharmacist   |
| <input type="checkbox"/> Licensed Counselor       | <input type="checkbox"/> Social Worker   |   |
| <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Physician Assistant                                   |   |
| <input type="checkbox"/> Other _____              | with surgical assist? <input type="checkbox"/> Yes <input type="checkbox"/> No | with immunization authority? <input type="checkbox"/> Yes <input type="checkbox"/> No           |

7. If you prescribe medication or medical devices, do you have a joint protocol with a collaborating physician who is licensed in NJ?  Yes  No

8. Do you prescribe controlled dangerous substances?  Yes  No

If yes, do you possess DEA certification and CDS registration?  Yes  No

### 9. CLAIMS UPDATE

Other than with Princeton, have any new claims been made against you?  Yes  No

Other than with Princeton, have any previously open claims been closed without indemnity payment?  Yes  No

Other than with Princeton, have any previously open claims been closed with indemnity?  Yes  No

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

10. 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**
- 

**If you answer yes to any of questions 11 through 21, please explain on a separate sheet and provide full documentation from any agency involved.**

11. Do you provide any services over the internet?  Yes  No
12. Do you know of any circumstance, act, error or omission that could possibly result in a professional liability claim against you?  Yes  No
13. Do you anticipate any changes in staff or services provided in the next year?  Yes  No
14. Are you in military service or employed full-time by the federal government?  Yes  No
15. Has any health care facility ever denied, suspended, revoked privileges or has probation been invoked?  Yes  No
16. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked?  Yes  No
17. Do you have a 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
18. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act?  Yes  No
19. Has a complaint against you ever been submitted to the Board of Medical Examiners or are you currently under investigation by a regulatory authority?  Yes  No
20. Do you treat patients at a correctional facility?  Yes  No
21. Do you practice in any labor and delivery or obstetrical-related areas?  Yes  No
22. **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 option waiver applied to your policy?  Yes  No

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

23. Is coverage desired for your professional entity?  Yes  No  
 If yes, name of entity \_\_\_\_\_  
 Federal Employer Identification Number \_\_\_\_\_
24. Does your entity employ any 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?  Yes  No  
**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.**
25. Is this a new entity formed within the last 12 months?  Yes  No

**Section II 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 policyholder \_\_\_\_\_ Date: \_\_\_\_\_

Print name of policyholder \_\_\_\_\_

I understand that 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.

**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 policyholder

\_\_\_\_\_  
Officer signature

\_\_\_\_\_  
Home Address\*

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

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

\_\_\_\_\_  
Home Phone Number\*

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

\_\_\_\_\_  
Witness to Medical Care Practitioner's signature

\*This information will only be used for cancellation notification and extended reporting offers only.