

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; 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. 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 above claims questions, you must provide copies of updated loss runs from your prior carrier.

7. 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 the questions 8 through 17, please explain on a separate sheet, and provide full documentation from any agency involved

8. Do you provide any services over the internet? Yes No

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

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

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

12. Has any health care facility ever denied, suspended, revoked privileges or has probation been invoked? Yes No

13. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked? Yes No
14. 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
15. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? Yes No
16. Has a complaint against you ever been submitted to the Chiropractic Board or are you currently under investigation by any regulatory authority? Yes No
17. Do you treat patients at a correctional facility? Yes No
18. Does your practice use or involve any of the following treatments: % of practice time
- a) Acupuncture or any piercing of the skin or tissue? Yes _____ % No
 - b) Magnets or crystals to treat or diagnose? Yes _____ % No
 - c) Selling vitamins, food supplements, herbal remedies? Yes _____ % No
 - d) Providing nutritional counseling? Yes _____ % No
 - e) Homeopathic remedies? Yes _____ % No
 - f) Treating animals? Yes _____ % No
 - g) Electrodiagnostic testing using Needle EMGs? Yes _____ % No
 - h) Performing manipulations under anesthesia (MUA)? Yes _____ % 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
19. 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

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

20. Is coverage desired for your professional entity? Yes No
- If yes, name of entity _____
- Federal Employer Identification Number _____
21. Does your entity have any employees, independent contractors, or partners that are 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.

22. 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. 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 Princeton Insurance Company.

Signature of Policyholder _____ Date _____

Policyholder

Policy

I understand that Princeton Insurance Company reserves the right to reject any applicant 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, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.