



## Healthcare Facility/Clinic Policy Renewal Application

Policy Number: \_\_\_\_\_ Tax ID#: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

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

Address: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

Do you participate as a principal investigator for any clinical trials?  Yes  No

If **yes**, do you follow FDA-approved protocols?  Yes  No

If **yes**, please explain: \_\_\_\_\_

In order for us to accurately evaluate your entity's coverage, please provide us with a breakdown of revenue generated at your office or at your hospital.

	Past 12 Months	Projected Next 12 Months
Total Patient Visits	_____	_____
Gross Receipts		
A) Generated at your Office	_____	_____
B) Generated at a Hospital	_____	_____
Payroll	_____	_____

**SURGICENTER ONLY: Number of Procedures:**

General \_\_\_\_\_ Oral \_\_\_\_\_ OB/GYN \_\_\_\_\_ OB/GYN Infertility \_\_\_\_\_

Podiatry \_\_\_\_\_ Orthopedic \_\_\_\_\_ Pain Management \_\_\_\_\_

Gastroenterology \_\_\_\_\_ Eye \_\_\_\_\_ Plastic \_\_\_\_\_ Other \_\_\_\_\_

Description of services provided (include brochures): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List ALL members, partners, stockholders and indicate which work at the organization and their positions:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is coverage desired for staff of this organization?  Yes  No

If **yes**, complete Appendix A - Staff Schedule of this application

If **no**, are employees required to maintain their own insurance?  Yes  No

If employees maintain their own insurance, at what limits? \$ \_\_\_\_\_

Do you require proof of insurance?  Yes  No

List Professional Staff or complete Appendix A: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SUPPLY COPIES OF CERTIFICATES OF INSURANCE AND CLAIMS HISTORY REPORT FOR ANY PROFESSIONAL STAFF THAT IS NOT INSURED BY PRINCETON INSURANCE COMPANY.

Signature of Officer: \_\_\_\_\_ Date: \_\_\_\_\_

**Appendix A - Staff Schedule**

Policy Number: \_\_\_\_\_

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

Do you anticipate any changes in staff or services provided by this entity in the next year?  Yes  No

**If yes, please describe:** \_\_\_\_\_  
 \_\_\_\_\_

List all professional staff including members, partners and shareholders (Physicians, Chiropractors, Dentists, etc.)

Name	Policy # if Princeton insured	License number	Specialty or position	Date of hire	Status		Avg. # hrs. per wk
					Employee	Independent Contactor	

List all Allied Professionals (RN, LPN, CRNA, Nurse Midwife, Techs, Social Worker, Occupational or Physical Therapist, Licensed Counselor, Physician Assist Non-Surg. or Surg., etc.)

Name	Policy # if Princeton insured	License number	Specialty or position	Date of hire	Status		Avg. # hrs. per wk
					Employee	Independent Contactor	

List all other clerical staff

Name	Position	Date of hire	Avg. # hrs. per wk.

*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: \_\_\_\_\_