Princeton Insurance
a MedPro Group/Berkshire Hathaway company

Physician and Surgeon Professional Liability
RENEWAL APPLICATION

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

SECTION I GENERAL INFORMATION

1. Policy Number _____ Policy Effective Date _____

2. Agency name and address _____

_____

Phone _____ Fax _____

1. Name and mailing address of applicant

_____

_____

_____

_____

Phone

Fax _____

Email _____

Website _____
(will be used to provide policyholder information only)

3. Birth date _____

4. License # and date for primary practice state _____

5. **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 payment? ☐ Yes ☐ No
If you answered "Yes" to any of the claim questions, you must provide copies of updated loss runs from your prior carrier

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

SECTION II PRACTICE LOCATIONS

7. 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*

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

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

	Loc #1		Loc #2		Loc #3	
	WK	MO	WK	MO	WK	MO
Actual patient care, including recordkeeping and hospital rounds						
Administrative duties						
Surgeries and assists						
House calls and nursing home visits						
Utilization review						
Teaching						
Total hours worked per week/month						

9. Specialty you currently practice _____

APPLICANT NAME _____

10. 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
- ☐ Intraoperative Monitoring
- ☐ 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
- ☐ Neuromonitoring _____% of total practice
- ☐ Oxidation Therapy
- ☐ Pacemakers - Epicardial
- ☐ Pacemakers - Endocardial
- ☐ Pacemakers - Temporary
- ☐ Peritonescopy
- ☐ 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)*

_____

_____

_____

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

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

_____

_____

APPLICANT NAME _____

SECTION III PHYSICIAN/SURGEON SERVICES

12. 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.

13. List procedures you perform that are not typical to the specialty in which you received your residency or fellowship training ☐ none
_____
_____
_____

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

15. To which medical societies or associations do you belong? _____

16. 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

17. 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: _____%

18. Do you practice in a nursing home facility? ☐ Yes ☐ No
If yes, indicate the percentage of your practice devoted to this activity: _____%

19. 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:_____

20. 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 16 through 20 please explain on a separate sheet, and provide full documentation from any agency involved.

21. 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	_____		

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

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

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

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

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

27. 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): _____

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

29. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

30. 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

31. 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.

32. 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.

33. Do you participate as a principal investigator for any clinical trials? ☐ Yes ☐ No
If yes, do you follow FDA-approved protocols? ☐ Yes ☐ No

34. **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

35. Is coverage desired for your professional entity? ☐ Yes ☐ No
If yes, name of entity_____
Federal Employer Identification Number_____

36. Does your entity employ any physicians, surgeons, podiatrists, dentists, case managers, chiropractors, physician assistants, surgical assistants, residents, nurse anesthetists, nurse midwives, nurse midwife assistants, nurse practitioners, nurse surgical assistants, clinical nurse specialists, perfusionists, occupational therapists, respiratory therapists, 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.

36. Is this a new entity formed within the last 12 months? ☐ Yes ☐ No

APPLICANT NAME _____

SECTION IV 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.

APPLICANT NAME _____

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 _____

_____
Medical Care Practitioner signature

_____
Print name of applicant

_____
Home address*

_____
City, State, Zip*

(_____) _____
Home Phone Number*

_____
Witness to Medical Care Practitioner's signature

Date _____

_____
Corporation

_____
Officer signature

_____
Print name of officer

_____
Address of corporation

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