

Allied Healthcare Provider Professional Liability Application

Section I General Information

1. Name and mailing address of applicant

Contact person _____

Phone (____) _____

Fax (____) _____

E-mail _____

(Will be used to provide policyholder information only.)

Website address _____

2. Agency name and address

Phone (____) _____

Fax (____) _____

Agent's website address _____

3. Birth date _____

4. Gender Male Female

5. Social Security # _____

6. Requested effective date _____

7. Type of coverage requested Claims-Made Occurrence (only available to certain classes)

8. Requested retroactive date _____ **If requesting prior acts coverage, the supplemental prior acts application must be completed and a copy of your current policy must be provided.**

9. Limits of liability requested \$1,000,000/\$3,000,000 \$2,000,000/\$4,000,000 (only available to certain classes)

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

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

12. Do you prescribe controlled dangerous substances? Yes No
If yes, do you possess DEA certification and CDS registration? Yes No

Practice Locations

13. List all locations where you currently work and/or anticipate working; indicate number of hours worked per week.

| Employer/Facility Name | Address | Employee or Independent Contractor | Total Hours Worked per week* |
|------------------------|---------|------------------------------------|------------------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Applicant name _____

14. Do you work for a physician who is currently insured by Princeton Insurance Company? Yes No
 If yes, (a) and working for an individual: Policy # _____; Affiliation Name: _____
 (b) and working in a group practice: Policy # _____; Affiliation Name: _____

15. Provide a detailed description of your principal activities while working

16. Are you an owner, operator, officer, partner or administrator or do you have a similar capacity for any health care or related services organization? If yes, please explain. Yes No

17. 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 _____

18. List all states in which you are or have ever been licensed or certified

| State | License # | Certificate # | Current Yes/No | State | License # | Certificate # | Current Yes/No |
|-------|-----------|---------------|----------------|-------|-----------|---------------|----------------|
| | | | | | | | |
| | | | | | | | |

19. School of graduation _____ Degree _____ Date _____

If you answer yes to any of questions 20 through 36, please explain on a separate sheet and provide full documentation from any agency involved.

20. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked? Yes No
21. Are you currently aware of any investigation being conducted which could impact your license? Yes No
22. 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
23. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? Yes No
24. Have you ever been accused of sexual misconduct of any kind? Yes No
25. Has your employment ever been terminated? Yes No
26. Have you incurred or become aware of having a condition that impairs your ability to practice your professional duties? (e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics, etc.) Yes No
*If yes, please state the condition, date(s) and identify your treating physician on a separate sheet. **In the event of such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.***
27. Are you in military service or employed full-time by the federal government? Yes No
28. Do you practice in any labor and delivery or obstetrical-related areas? Yes No
29. Do you provide any services over the internet? Yes No
30. Do you treat federal or non-federal prison inmates? Yes No
*If yes, (a) what percentage of your practice is devoted to each? federal _____% non-federal _____%
 (b) are you covered by another insurance for this activity? Yes No*
31. Do you know of any circumstance, acts, errors, or omissions that could possibly result in a professional liability claim against you? Yes No
32. Do you anticipate any changes in staff or services provided in the next year? Yes No

Applicant name _____

- 33. Have you ever practiced without professional liability coverage? Yes No
- 34. Has your professional liability coverage ever been written with a non-admitted carrier? Yes No
- 35. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? Yes No
- 36. Has any company ever cancelled, not renewed or refused coverage? Yes No
- 37. Name of current professional liability insurance carrier _____
 Policy # _____
 Type of Coverage Occurrence Claims-Made Expiration date _____

Loss runs from all prior carriers are required. If Claims-Made, was tail purchased? Yes No

38. Have any claims ever been made against you? Yes No

| Plaintiff name | Incident date | Report date | Status* | Settlement amount/date | Insurance company | Description of claim |
|----------------|---------------|-------------|---------|------------------------|-------------------|----------------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

If yes, complete the following:
* Open, closed without payment, closed with payment.

39. **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

40. Is coverage desired for your professional entity? Yes No
 If yes, name of entity _____
 Federal Employer Identification Number _____

41. 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.

Section II Signature

This section must be completed by all applicants.
 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 as well as the company's calculation of the applicable premium should a policy be issued. As a result, I agree to inform the company of any changes to my practice. I authorize release and exchange of any underwriting or claims information between all prior carriers and Princeton Insurance Company.

Signature of applicant: _____ Date: _____

Print name of applicant: _____

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.

