Allied Healthcare Provider Professional Liability Application

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Princeton Insurance
a MedPro/Berkshire Hathaway company

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

- ☐ Optician
- ☐ Optometrist
- ☐ Psychiatric Nurse
- ☐ Physical Therapist
- ☐ Psychologist
- ☐ Licensed Counselor
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Student Nurse
- ☐ X-Ray Therapist
- ☐ First Nurse Surgical Assistant
- ☐ Dental Assistant/Hygienist
- ☐ Social Worker
- ☐ Physician Assistant
  with surgical asst? ☐ Yes ☐ No
- ☐ Advanced Practice Nurse - Nurse Anesthetist
- ☐ Advanced Practice Nurse - Clinical Nurse Specialist
  Specialty_____
- ☐ Advanced Practice Nurse - Nurse Practitioner
  Specialty_____
- ☐ Pharmacist
  with immunization authority? ☐ Yes ☐ No
- ☐ 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.

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	Date
Medical Care Practitioner ignature	Corporation
Print name of applicant	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.