Chiropractor Professional Liability Application

Princeton Insurance
a MedPro/Berkshire Hathaway company

Chiropractor Professional Liability Application

Section I General Information

1. Name and address of applicant

____
____
____
____

Contact person ______________________
Phone (____) ______________________
Fax (____) ______________________
E-mail ______________________
(Will be used to provide policyholder information only.)

Website ______________________

2. Agency name and address

____
____
____
____

Phone (____) ______________________
Fax (____) ______________________
E-mail ______________________
Website ______________________

3. Birth date______________________
4. Gender ☐ Male ☐ Female
5. Social Security #______________________
6. License # and date for primary practice state______________________
7. Type of coverage requested ☐ Claims-Made ☐ Occurrence Plus
8. Requested effective date______________________ ☐ Non-binding indication only ☐ Formal quote*

**If a formal quote is requested and results in an declination, the declination will be reported to the Department of Insurance.*

9. 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.**

Practice Locations

10. List all locations where you currently and/or anticipate working; indicate the 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, recordkeeping, administrative duties, teaching, house calls, nursing home visits, utilization review.*

11. Name of present insurance carrier______________________
Expiration date______________________
Type of present policy (attach copy of prior policy) ☐ Occurrence Plus (Modified Claims-Made) ☐ Occurrence ☐ Claims-Made

Loss runs from all prior carriers are required. If claims-made, was tail purchased? ☐ Yes ☐ No

12. Previous professional liability insurance carrier(s)

Company Name	Policy #	Coverage Date		Occurrence/Occurrence Plus/Claims Made	Retro. Date
		Eff.	Exp.		

If you answer yes to any of questions 13, 14, or 15, please provide full details on a separate sheet.

13. Have you ever practiced without professional liability coverage? ☐ Yes ☐ No
14. Has your professional liability coverage ever been written with a non-admitted carrier? ☐ Yes ☐ No
15. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? ☐ Yes ☐ No

Applicant name_______________________________

16. If you are employed by someone else, please complete the following

  a) Name of employer_______________________________

  b) Name of employer's professional liability insurer_______________________________

  (If your employer is to pay the premium for your coverage, refer to Assignment of Unearned Premium form.)

Section II Practice Information

1. List all facilities or organizations where you have practiced or have had staff our courtesy privileges for your profession since graduation. Explain any periods of inactivity.

Facility Name and Location | Department | Type of Privileges | Dates From/To

____

____

____

2. List all states in which you are licensed or have been licensed and information on that state license, if applicable.

State	License #	Active Yes/No	# of Patients	% of Income	% of Office Hours

3. Do you have a position for which no coverage is required, or for which you are insured with another carrier? ☐ Yes ☐ No

____

____

____

4. Has anyone ever filed a claim against you regardless of whether the claim was dismissed or a judgment was rendered? If yes, please complete a supplemental claims application for each claim. ☐ Yes ☐ No

If you answer yes to any of questions 5 through 15, please explain on a separate sheet and provide full documentation from any agency involved.

5. Do you know of any circumstance, act, error or omission that could possibly result in a professional liability claim against you? ☐ Yes ☐ No
6. Do you anticipate any changes in staff or services provided in the next year? ☐ Yes ☐ No
7. Are you in military service or employed full-time by the federal government? ☐ Yes ☐ No
8. Do you treat patients at a correctional facility? ☐ Yes ☐ No
9. Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked? ☐ Yes ☐ No
10. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered, or has probation been invoked? ☐ Yes ☐ No
11. 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
12. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? ☐ Yes ☐ No
13. Has your professional liability coverage ever been cancelled, restricted, non-renewed, declined or have you withdrawn an application for insurance to avoid declination? ☐ Yes ☐ No
14. Has a complaint against you ever been submitted to the New Jersey State Board of Chiropractic Examiners or are you currently under investigation by any regulatory authority? ☐ Yes ☐ No
15. Do you provide any services over the internet? ☐ Yes ☐ No

Applicant name____

16. **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

Section III Required Documentation

1. Claim history reports (loss runs) from all prior insurance carriers
2. Copy of current declarations page from your current insurance carrier
3. Copy of current New Jersey license
4. Curriculum vitae

Section IV Chiropractor Services

1. Indicate professional liability limits desired

   ☐ $100,000/$300,000 ☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000

2. School of Graduation________________________________ Graduation Date________________Degree________________

3. Date of License____

4. 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 EMG? ☐ Yes %_________ ☐ No
   h) Performing manipulations under anesthesia (MUA)? ☐ Yes %_________ ☐ No

   If yes, is the person administering the anesthesia an MD or OD 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

5. Do you offer services other than chiropractic care? ☐ Yes ☐ No

   If yes, please explain____

6. List the state or municipal licensing requirements with which you currently comply to practice in your field

   ____ ☐ None required

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

1. Is coverage desired for your professional entity? ☐ Yes ☐ No

   If yes, name of entity____

   Federal Employer Identification Number______________________________________

Applicant name____

2. Does your entity have any employees, independent contractors or partners? ☐ Yes ☐ No

(Employees and independent contractors are defined as 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.)

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 V Signature

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 should a policy be issued. 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 ____

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 ______________________

Supplemental Claims Information

(If more than four (4) claims, please photocopy this page, complete and attach)

Please complete, in chronological order, for any closed, pending or potential claim.

1. Claimant's/plaintiff's name ______________________
   Date care rendered ______________ Date claim reported ______________
   Status: ☐ Open ☐ Closed Date closed ______________
   If closed, was any indemnity payment or award made? ☐ Yes ☐ No **If yes, amount** ______________
   If open, what is the amount of loss reserve or damages sought? ______________
   Name of insurance company defending you ______________
   Description of claim (include type of treatment, result of treatment, your involvement) ______________

2. Claimant's/plaintiff's name ______________________
   Date care rendered ______________ Date claim reported ______________
   Status: ☐ Open ☐ Closed Date closed ______________
   If closed, was any indemnity payment or award made? ☐ Yes ☐ No **If yes, amount** ______________
   If open, what is the amount of loss reserve or damages sought? ______________
   Name of insurance company defending you ______________
   Description of claim (include type of treatment, result of treatment, your involvement) ______________

3. Claimant's/plaintiff's name ______________________
   Date care rendered ______________ Date claim reported ______________
   Status: ☐ Open ☐ Closed Date closed ______________
   If closed, was any indemnity payment or award made? ☐ Yes ☐ No **If yes, amount** ______________
   If open, what is the amount of loss reserve or damages sought? ______________
   Name of insurance company defending you ______________
   Description of claim (include type of treatment, result of treatment, your involvement) ______________

4. Claimant's/plaintiff's name ______________________
   Date care rendered ______________ Date claim reported ______________
   Status: ☐ Open ☐ Closed Date closed ______________
   If closed, was any indemnity payment or award made? ☐ Yes ☐ No **If yes, amount** ______________
   If open, what is the amount of loss reserve or damages sought? ______________
   Name of insurance company defending you ______________
   Description of claim (include type of treatment, result of treatment, your involvement) ______________

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*

____
Witness to Medical Care Practitioner's signature

Date:____

____
Corporation

____
Officer signature

____
Print officer name

____
Address of corporation

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

Appendix A - Staff Schedule

Entity Name ____

List all owners, partners, independent contractors, and employees (physicians, chiropractors, dentists, etc.)

Name	Policy #, if Princeton Insured	License Number	Specialty or Position	Date of Hire	Avg # of Hrs Per Week

List all allied professionals (RN, LPN, CRNA, Nurse Midwife, Tech, Medical Assistant, Social Worker, Occupational or Physical Therapist, Licensed Counselor, Physician Assistant-Surgery or Non-Surgery, etc.)

Name	Policy #, if Princeton Insured	License Number	Specialty or Position	Date of Hire	Avg # of Hrs Per Week

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________________________

Applicant name ______________________________

Appendix B - Organization Application

1. Name of entity ______________________________
   Address ______________________________
   Tax ID# ______________________________
   Retroactive date ______________________________

2. a) Description of operations performed ______________________________
   b) Description of services performed ______________________________

	Past 12 Months	Projected Next 12 Months
Patient visits (each encounter)	__________	__________
Gross receipts	__________	__________
Payroll	__________	__________
Other	__________	__________

3. Are overnight facilities available? ☐ Yes ☐ No

4. Hours of operation ______________________________

5. Describe the type of entity and ownership (check all that apply)

_____ Professional Association
_____ Corporation
_____ Joint Venture
_____ For Profit
_____ Other, describe ______________________________
_____ Partnership
_____ Community Clinic (non-profit)
_____ Partnership, Limited
_____ Not for Profit

6. Are there subsidiaries that are to be included in this coverage? ☐ Yes ☐ No
   If yes, please list name of subsidiary and provide a current organizational chart.
   ____

7. List members, shareholders, etc.
   ____

8. How long has the entity been in business? _____ Years _____ Months

9. Does the entity have a written quality assurance/risk management program? ☐ Yes ☐ No

10. Has the entity ever been sued regardless of whether the claim was dismissed on a judgment rendered? ☐ Yes ☐ No
    If yes, please complete supplemental claims information sheet.

11. Name of current professional liability insurance carrier ______________________________
    Please attach a copy of the declarations page showing: retro date, limits of liability, policy period and any restrictive endorsements.

12. Has your professional liability insurance ever been cancelled, refused or non-renewed? ☐ Yes ☐ No

13. Are procedures in place for patient transfers to another facility in the event of an emergency? ☐ Yes ☐ No
    If yes, please describe
    ____
    ____

14. Are medications administered? ☐ Yes ☐ No
    If yes, by whom?
    ____

15. **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

Complete Appendix B for each organization named.
Attach copies of all advertising materials, stationary, telephone directory yellow pages, handouts and other advertising.