Princeton Insurance
a MedPro Group/Berkshire Hathaway company

# Physician and Surgeon Professional Liability
APPLICATION

## SECTION I GENERAL INFORMATION

1. Name and mailing address of applicant

_____
_____
_____
Contact person: _____
Phone (_____) _____
Fax (_____) _____
E-mail _____
Website address _____

2. Agency name and address

_____
_____
_____
_____
Phone (_____) _____
Fax (_____) _____

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 ☐ Occurrence

8. Indicate professional liability limits desired
☐ $1,000,000/ $3,000,000 ☐ $2,000,000/ $4,000,000 (If higher limits are desired, please refer to company.)

9. Requested effective date _____ ☐ Non-binding indication only ☐ Formal quote*
***If a formal quote is requested and it results in a declination, the declination must, by law, be reported to the Department of Insurance.***

10. Requested retroactive date _____ If requesting prior acts coverage – coverage for your practice before the effective date listed in response to #8 above – the supplemental prior acts application must be completed and a copy of your current policy must be provided..

11. 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.***

12. 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** | | | | | | |

13. List all locations where you will be working for which you have other coverage and are not applying for this insurance.

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

14. Name of present insurance carrier _____
Expiration date _____
Type of present policy (Attach copy of policy) ☐ Occurrence Plus (Modified Claims-Made) ☐ Occurrence
☐ Claims-Made - If claims-made, was tail purchased? ☐ Yes ☐ No
***Loss runs from all prior carriers are required.***

15. Previous professional liability insurance carrier(s):

| Company Name | Policy # | Coverage Date | | Occurrence/ Occurrence Plus/ Claims Made | Retroactive Date |
|---|---|---|---|---|---|
| | | Eff. | Exp. | | |
| | | | | | |
| | | | | | |
| | | | | | |

16. If you are employed by someone else, please answer the following
Name of employer _____
Name of employer's professional liability carrier _____
*(If your employer is to pay the premium for your coverage, the Assignment of Unearned Premium Form must be completed.)*

***If you answer yes to questions 17, 18, 19 or 20, please provide full details on a separate sheet.***

17. Have you ever practiced without professional liability coverage? ☐ Yes ☐ No
18. Has your professional liability coverage ever been written with a non-admitted carrier? ☐ Yes ☐ No
19. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? ☐ Yes ☐ No
20. Do you know of any circumstance, act, error or omission that could possibly result in a professional liability claim against you? ☐ Yes ☐ No
21. 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

## SECTION II PRACTICE LOCATIONS

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

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

2. Do you admit patients to any of the above hospital(s)? ☐ Yes ☐ No
If no, please explain your protocol to admit patients to a hospital, if the circumstances would arise, on a separate sheet

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

| State | License # | DEA License # | Active Yes/No | # of Patients | % of Hospital Procedures | % of Income | % of Office Hours |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

4. Are you entering private practice for the first time? ☐ Yes ☐ No

5. Please explain the following gaps if they occurred in the last ten (10) years:
   (a) Gaps greater than one (1) year between your medical school, residency, other training or first time in practice.
   _____
   (b) Gaps greater than six (6) months between practice locations.
   _____

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

7. 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

8. 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: _____%

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

10. 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:_____

11. 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 13 through 22 please explain on a separate sheet, and provide full documentation from any agency involved.***

12. 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 | _____ | | |

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

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

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

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

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

18. 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): _____

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

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

21. Has your professional liability coverage ever been cancelled, restricted, non renewed, declined, or have you withdrawn an application for insurance to avoid declination, or have you ever had an involuntary deductible or surcharge assessed against your policy? ☐ 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. Do you participate as a principal investigator for any clinical trials? ☐ Yes ☐ No
If yes, do you follow FDA-approved protocols? ☐ Yes ☐ No

24. **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 PHYSICIAN/SURGEON SERVICES

1. 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.

2. Specialty you currently practice: _____|

3. Are you permanently retired from the practice of clinical medicine? ☐ Yes ☐ No

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

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

6. Have there been any changes in your specialty, classification, or practice activity within the past ten years? ☐ Yes ☐ No
Have you discontinued performing minor or major surgical procedures within the past ten years? ☐ Yes ☐ No
***If yes, list procedures/activities, reason for and date of change(s) on a separate sheet.***

7. Have you performed weight control surgery or prescribed weight control medication within the past ten years? ☐ Yes ☐ No
Do you have ownership or financial interests in a weight control clinic? ☐ Yes ☐ No

8. Do you work in an emergency room on a scheduled basis? ☐ Yes ☐ No
***If yes:*** (a) indicate average number of hours per month devoted to in-hospital emergency room care (not on-call hours) _____
(b) on average how many of the above hours are you working in order to fulfill staff privilege requirements? _____

9. 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.***

10. 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.***
11. Have you ever failed any licensing or board certification or recertification examination? ☐ Yes ☐ No
    ***If yes, please provide name(s) of exam(s) and number of times failed on a separate sheet.***
12. Medical school _____ Date of graduation _____
13. If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates? ☐ Yes ☐ No
14. Are you currently an intern, resident or fellow? ☐ Yes ☐ No
    ***If yes, what will be the final date of internship, residency or fellowship?***
15. Where did you serve
    Internship _____ Date of completion _____
    Residency _____ Specialty _____ Date of completion _____
    Fellowship _____ Specialty _____ Date of completion _____

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PROCEED TO NEXT PAGE

APPLICANT NAME _____

16. 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)*
  _____
  _____
  _____

17. 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 _____

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

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

19. Does your entity have any employees, independent contractors or partners that are: ☐ Yes ☐ No

| | | | | |
|---|---|---|---|---|
| ☐ Aestheticians | ☐ Nurse Anesthetists | ☐ Occupational Therapists | ☐ Psychologists | ☐ Surgical Assistants |
| ☐ Case Managers | ☐ Nurse Midwives | ☐ Podiatrists | ☐ Residents | |
| ☐ Chiropractors | ☐ Nurse Midwife Assistants | ☐ Perfusionists | ☐ Respiratory Therapists | |
| ☐ Clinical Nurse Specialists | ☐ Nurse Practitioners | ☐ Physicians | ☐ Social Workers | |
| ☐ Dentists | ☐ Nurse Surgical Assistants | ☐ Physician Assistants | ☐ Surgeons | |

**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

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 _____

## 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*

( _____) _____
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.

APPLICANT NAME _____

## APPENDIX A - STAFF SCHEDULE

Entity name: _____

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

| Name | Policy #, if Princeton Insured | License # | Specialty or Position | Date of Hire | Average # of Hrs Per Week |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

| Name | Policy #, if Princeton Insured | License # | Specialty or Position | Date of Hire | Average # 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 organization _____
   Address _____
   Tax ID# _____
   Effective date _____ Retroactive date _____
   Policy Type: ☐ Claims-Made ☐ Occurrence ☐ Occurrence Plus

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 organization and ownership. *(Check all that apply)*

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

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 organization been in business? _____ Years _____ Months

9. Does the organization have a written Quality Assurance/Risk Management Program? ☐ Yes ☐ No

10. Has the organization ever been sued regardless of whether the claim was dismissed or a judgment rendered? ☐ Yes ☐ No
    (***If yes, please complete a 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 canceled, 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. Do you perform consultations, render medical services, offer 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.***

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

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

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 Date

_____
Print name