Princeton Insurance
a MedPro/Berkshire Hathaway company

Allied Healthcare Provider Professional Liability Renewal Application

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

Policy Number_____ Policy Effective Date_____

1. Agency name and address_____

_____

Phone_____ Fax_____

2. Name and mailing address of insured
_____ Phone_____
_____ Fax_____
_____ E-mail_____
(will be used to provide policyholder information only.)
_____ Website_____

3. Birthdate_____

4. License # for primary practice state_____

PRACTICE LOCATIONS

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

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

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

6. Do you practice as

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

7. 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 for a group practice: policy #_____; affiliation name _____

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

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

10. **CLAIMS UPDATE**
    Other than with Princeton, have any new claims been made against you? ☐ Yes ☐ No

Policyholder Name _____

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? ☐ Yes ☐ No

If you answered "Yes" to any of the claim questions, you must provide copies of updated loss runs from your prior carrier.

11. 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

_____

If you answer yes to any of questions 12 through 23, please explain on a separate sheet and provide full documentation from any agency involved.

12 Do you provide any services over the internet? ☐ Yes ☐ No

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

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

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

16. Has any health care facility ever denied, suspended, 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? (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics or other controlled substances, etc.) ☐ Yes ☐ No
If yes, state condition(s) and date(s) and identify your treating physician(s) on a separate sheet. **In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

19. Have you ever been charged with a criminal offense or are your 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 a complaint against you ever been submitted to the Board of Medical Examiners or are you currently under investigation by a regulatory authority? ☐ Yes ☐ No

22. Do you treat patients at a correctional facility? ☐ Yes ☐ No
If yes, (a) what percentage of your practice is devoted to each: federal prison inmates: _____ %, non-federal prison inmates: _____%
(b) are you covered by another insurance for this activity? ☐ Yes ☐ No

23. Do you practice in any labor and delivery or obstetrical-related areas? ☐ 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 option waiver applied to your policy? ☐ Yes ☐ No

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

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

If yes, name of entity_____

Federal Employer Identification Number_____

26. 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.

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

Policyholder Name _____

Section II 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 for a policy as well as the Company's calculation of the applicable premium issued by Princeton Insurance Company. 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 policyholder _____ Date: _____

Print name of policyholder _____

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.

Policyholder 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 signature Corporation

_____ _____

Print name of policyholder 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.