
Organization Professional Liability Application

Princeton Insurance

We're there.



Princeton Insurance, a MLMIC Group company

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Field Office: 4 North Park Drive, Suite 510, Hunt Valley, Maryland 21030-1880

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(877) PI-EASY2
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8. Number of locations: _____

Addresses: _____

past
12 months

projected
next 12 months

9. Patient visits (each encounter): _____

10. Gross receipts: _____

11. Payroll: _____

Financial Statements may be necessary.

12. Are overnight facilities available? Yes No

13. Hours of operation: _____

14. Please describe the nature of the services performed. Attach a copy of advertising material, stationery, telephone directory yellow pages, handouts or other ad.

15. Is coverage desired for staff of this organization? Yes No
If yes, complete Appendix A of this application.

If no, are employees required to maintain their own insurance? Yes No

If employees maintain their own insurance, at what limits? \$ _____

Do you require proof of insurance? Yes No

16. Describe the type of organization and ownership: (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Professional Association | <input type="checkbox"/> Partnership, General | <input type="checkbox"/> Corporation |
| <input type="checkbox"/> Community Clinic (non-profit) | <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Partnership, Limited |
| <input type="checkbox"/> For Profit | <input type="checkbox"/> Not for Profit | |
| <input type="checkbox"/> Other, describe: _____ | | |

17. List all members, partners, or stockholders. Indicate which ones work at the organization and their positions. (If available, provide an organizational chart that illustrates all relevant personnel and the structure of your organization, including any relationships with other organizations.)

18. How long has the organization been in business? _____ Years _____ Months

19. Has the organization ever been sued or have any claims been made against it? Yes No
If yes, attach a copy of insurance company's loss run(s).

20. Name of current professional liability insurance carrier: _____
Attach a copy of the declarations page showing: retroactive date, limits of liability, policy period, and any restrictive endorsements.

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

If yes, for what reason and when? _____

22. List the state or municipal licensing requirements with which the facility complies.

None required.

23. Are radiation or shock therapy, nitrous oxide (or any other anesthetics) administered on site? Yes No

24. If anesthesia machines are used, are they all equipped with fail-safe devices? Yes No

25. Are abortions performed on site? Yes No

If yes, how many within the past 12 months? _____

26. Are procedures in place for patient transfers to another facility in the event of an emergency? Yes No

If yes, please describe: _____

27. Are medications administered? Yes No

If yes, by whom? _____

28. Do you provide services over the internet? Yes No

29. Do you treat patients at a correctional facility? Yes No

30. Do you provide weight loss/bariatric services? Yes No

31. Are physicians' services rendered? Yes No

If yes, are the physicians: private physicians
 contracted physicians
 employed physicians

32. Has the organization applied for an inspection by JCAHO? Yes No

If yes, provide a copy of the inspection report, including status and contingencies, and a copy of the most recent inspection summary.

If no, explain why the organization has not applied or why the organization is not eligible.

33. List names of employed personnel who are certified in CPR or ALCS.

34. Does the organization have a written Quality Assurance/Risk Management Program? Yes No
35. Name of designated Risk Manager: _____
Phone number: (____) _____
36. Are there subsidiaries that are to be included in this coverage? Yes No
- If yes, please list the name of each subsidiary, and provide a current organizational chart.

Complete an Organization Application for each organization named.

37. Does the facility have any non-expendable medical, dental or surgical machines or services that are used for diagnostic or treatment procedures by individuals other than members of your organization? Yes No
38. Do you sell or lease any medical equipment or other product in connection with your operation? Yes No
- If yes, please describe: _____
-
-
39. If you lease equipment to others, do you provide maintenance on the equipment? Yes No
- If yes, please describe: _____
-
-

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 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 the Princeton Insurance Company. I understand that Princeton Insurance Company reserves the right to reject any applicant that does not meet its underwriting standards.

Signature of Applicant

Date

NOTICE TO PENNSYLVANIA AND NEW JERSEY APPLICANTS: 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.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH THE 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

