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# Health Care Professional Application

**Princeton Insurance**

*We're there.*



Princeton Insurance, a MLMIC Group company

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746 Alexander Road, Princeton, New Jersey 08540-6305

**[www.princetoneasyaccess.com](http://www.princetoneasyaccess.com)**

**(877) PI-EASY2**

**(877) 743-2792**

# Health Care Professional Application

## Section I General Information

1. Name and address of applicant

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Contact person \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_\_) \_\_\_\_\_  
 E-mail \_\_\_\_\_

2. Agency name and address

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_\_) \_\_\_\_\_  
 E-mail \_\_\_\_\_

3. Birth date \_\_\_\_\_ 4. Social Security # \_\_\_\_\_

5. License # and date for primary practice state \_\_\_\_\_

6. Type of coverage requested  
 Claims-Made     Occurrence     Occurrence Plus

7. Is prior acts coverage requested?     Yes     No  
 (If yes, please attach copy of current policy and complete prior acts application)

8. Requested effective date \_\_\_\_\_     Non-binding indication only     Formal Quote\*  
*\* If a formal quote is requested and it results in a declination, the declination will be reported to the Department of Insurance.*

Requested retroactive date \_\_\_\_\_  
 (If requesting prior acts coverage, the supplemental prior acts application must be completed)

9. Type of practice (Check all that apply)  
 Employee                                     Sole proprietor/Unincorporated     Limited liability corporation  
 Professional association                 Independent contractor                 Principal in a professional corporation  
 Partnership                                     Other (describe) \_\_\_\_\_

10. Is coverage desired for the organization?     Yes     No  
 If yes, name of organization \_\_\_\_\_  
 (For associations with more than one member, employee or independent contractor involved, complete Appendix C)

11. For solo corporations only: Do you wish to include coverage for your professional corporation or professional association on this policy?     Yes     No  
 (If yes, name of organization\*) \_\_\_\_\_ Tax ID# \_\_\_\_\_  
*\*This organization will share the limit of liability of the individual*

12. List all locations where you work. (Mail will be sent to address #1 below unless otherwise indicated)

	Employer/Facility Name	Street	City	County	State	Zip	Phone
#1	_____						
#2	_____						
#3	_____						

13. Please indicate (if applicable) total hours worked per week and month at each office location for the following activities.

	Loc. #1		Loc. #2		Loc. #3	
	WK	MO	WK	MO	WK	MO
a. Actual patient care, including recordkeeping and hospital rounds						
b. Administrative duties						
c. Surgeries and assists						
d. House calls and nursing home visits						
e. Utilization review						
f. Teaching						
<b>Total hours worked per week</b>						

14. Name of present insurance carrier \_\_\_\_\_

Expiration date \_\_\_\_\_

Type of present policy (Attach copy of prior policy)  Occurrence Plus (Modified Claims Made)  Occurrence  
 Claims-Made Tail purchased?  Yes  No

15. Previous professional liability insurance carrier(s):

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

16. If you are employed by someone else, please answer 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 Appendix A)

**Section II Practice Information**

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**

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

3. Is coverage desired for your staff?  Yes  No  Not Applicable  
(If yes, please complete Appendix B of this application)

4. 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)


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

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

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

8. Do you work for a correctional facility (jail)?  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. Are you currently being treated for a psychiatric condition, alcoholism or substance abuse?  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 Board of Medical Examiners or are you currently under investigation by any regulatory authority?  Yes  No
- 15. Do you provide any services over the internet?  Yes  No

**(If you answered yes to any of questions 7 through 15, please explain on a separate sheet, and provide full documentation from any agency involved)**

**Section III 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 should a policy be issued. I authorize the release and exchange of any underwriting or claims information between all prior carriers and the Princeton Insurance Company.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Princeton Insurance Company reserves the right to reject any application 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.

**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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Appendix A Assignment of Unearned Premium**

1. If the premium payer is other than the named insured, is this insurance assigned to the payer?  Yes  No

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 policy term beginning \_\_\_\_\_, 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 policies 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 policies 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.
- 4. The MCP agrees not to further assign any interest in said professional liability policies without The Corporation's written consent.

Date \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Medical Care Practitioner

\_\_\_\_\_  
Corporation

\_\_\_\_\_  
Officer

\_\_\_\_\_  
Witness to Medical Care Practitioner's signature

\_\_\_\_\_  
Address of Corporation

**Appendix B**

1. List all staff including members, partners and shareholders (Use and attach additional sheet, if necessary)

Name	Policy # if Princeton insured	License Number	Specialty or position	Date of hire	Employee	Status: Independent or Contractor	Avg. # hours per wk.

List all other staff

Name	Position	Date of Hire	Avg. # hrs. per wk.

*If coverage is not desired for independent contractors, attach certificates of insurance for all individuals or a copy of their professional liability policy.*

**Managed Care Supplemental Application**

1. List name and address of all managed care groups with whom you are affiliated:

Group Name	Street	City	State	Zip

- 2. Do you authorize a certificate of insurance to be sent to these groups?  Yes  No
- 3. Does the contract require you to participate in arbitration?  Yes  No

I authorize the group(s) listed in #1 above to provide a copy of the managed care contract to Princeton Insurance Company upon request.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**We strongly recommend that your personal legal counsel review your managed care contract to insure that your interests are protected.**

**Appendix C**

1. Name of organization \_\_\_\_\_  
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 organization 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. List members, shareholders, etc. \_\_\_\_\_

7. How long has the organization been in business? \_\_\_\_ Years \_\_\_\_ Months

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

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

10. 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)

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

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

13. Are medications administered?  Yes  No  
If yes, by whom?

14. 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)

**Complete Appendix C for each organization named.**

**Physician/Surgeon**

1. Indicate professional liability limits desired

- \$1,000,000/\$3,000,000       \$2,000,000/\$4,000,000

2. Please indicate the applicable percentage of your practice (total should equal 100%).

- \_\_\_\_\_ % MAJOR SURGERY — performing major surgery or assisting in major surgery on patients other than your own. (Includes, but is not limited to, tonsillectomies, adenoidectomies, liposuction or procedures requiring general anesthesia.)
- \_\_\_\_\_ % OBSTETRICS — number of deliveries per year \_\_\_\_\_  
                   \_\_\_\_\_ % pregnancy terminations  
                   \_\_\_\_\_ % first trimester terminations  
                   \_\_\_\_\_ % second trimester terminations
- \_\_\_\_\_ % MINOR SURGERY — performing minor surgery or assisting in major surgery on your own patients. (Includes, but is not limited to, circumcision, cardiac catheterization, pacemaker insertion or needle biopsy for lung and prostate, colonoscopy, upper G.I. endoscopy or laparoscopy.)
- \_\_\_\_\_ % NO SURGERY — medical practice which may include incising of boils and abscesses, removal of superficial skin lesions, suturing minor lacerations and Swan Ganz catheters.

3. Medical School \_\_\_\_\_ Date of Graduation \_\_\_\_\_

4. Where did you serve:

Residency or Internship? \_\_\_\_\_ Date of Completion \_\_\_\_\_  
 Fellowship? \_\_\_\_\_ Date of Completion \_\_\_\_\_  
 Specialty of Residency or Fellowship \_\_\_\_\_ Subspecialty \_\_\_\_\_

5. Specialty you currently practice \_\_\_\_\_

6. Are you board certified by an AMA-approved specialty board?  Yes  No  
 Name of specialty board \_\_\_\_\_ Date of last certification \_\_\_\_\_

7. If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates?  Yes  No

8. Are you currently an intern, resident or fellow?  Yes  No  
 If yes, what will be the final date of internship, residency or fellowship? \_\_\_\_\_

9. Do you provide weight loss/bariatric services?  Yes  No  
 If yes, what percent? \_\_\_\_\_

10. Do you administer Botox injections in any non-clinical setting?  Yes  No

USE THIS SPACE FOR ADDITIONAL INFORMATION.