



746 Alexander Road  
Princeton, NJ 08540-6305  
[www.PrincetonInsurance.com](http://www.PrincetonInsurance.com)

## Healthcare Facility/Clinic Professional Liability Application

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**Princeton Insurance**  
PARTNERSHIP. PREVENTION. PROTECTION.

(800) 334-0588



# Healthcare Facility/Clinic Professional Liability Application

Issue    Quote

1. Name and mailing address of applicant

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

Contact person \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_) \_\_\_\_\_

**E-mail** \_\_\_\_\_  
(Will be used to provide policyholder information only.)  
 Website Address \_\_\_\_\_

2. Name and mailing address of agent

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

Phone (\_\_\_\_) \_\_\_\_\_  
 Fax (\_\_\_\_) \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Agent's Website Address \_\_\_\_\_

3. Tax ID # \_\_\_\_\_ License # \_\_\_\_\_

4. Type of coverage requested

Claims-Made    Occurrence Plus

5. Requested effective date \_\_\_\_\_

6. 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.)*

7. Professional liability - limits of liability requested

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

8. This organization operates as: (Check each box that applies)

- |                                                            |                                                     |
|------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Chiropractic Clinic               | <input type="checkbox"/> Dialysis Center            |
| <input type="checkbox"/> Emergency (free standing ER)      | <input type="checkbox"/> Health Center              |
| <input type="checkbox"/> Health Center - All Other         | <input type="checkbox"/> Hospice                    |
| <input type="checkbox"/> Laboratory:                       | <input type="checkbox"/> Medical Registry           |
| <input type="checkbox"/> Dental                            | <input type="checkbox"/> Visiting Nurse Association |
| <input type="checkbox"/> Medical                           | <input type="checkbox"/> Urgicenter                 |
| <input type="checkbox"/> Pathology                         | <input type="checkbox"/> Other, describe: _____     |
| <input type="checkbox"/> X-Ray                             |                                                     |
| <input type="checkbox"/> All Other                         |                                                     |
| <input type="checkbox"/> Rehab Facility                    | <input type="checkbox"/> Cardiac                    |
|                                                            | <input type="checkbox"/> Development/Disability     |
|                                                            | <input type="checkbox"/> Occupational               |
|                                                            | <input type="checkbox"/> Substance                  |
|                                                            | <input type="checkbox"/> Trauma                     |
| <input type="checkbox"/> Surgicenter: Number of Procedures |                                                     |
| ___ General                                                | ___ Podiatry                                        |
| ___ Oral                                                   | ___ Bariatric                                       |
| ___ OB/GYN                                                 | ___ Orthopaedic                                     |
| ___ Infertility                                            | ___ Other: _____                                    |
| ___ Gastroenterology                                       |                                                     |
| ___ Ophthalmology                                          |                                                     |
| ___ Plastic                                                |                                                     |

9. Number of locations: \_\_\_\_\_

Addresses: \_\_\_\_\_  
 \_\_\_\_\_

	past 12 months	projected next 12 months
10. Patient Visits (each encounter):	_____	_____
11. Gross receipts:	_____	_____
12. Payroll: <small>Financial Statements may be necessary.</small>	_____	_____

Name: \_\_\_\_\_

13. Are overnight facilities available?  Yes  No

14. Hours of operation: \_\_\_\_\_

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

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

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

- Professional Association     Partnership, General     Corporation  
 Community Clinic (non-profit)     Joint Venture     Partnership, Limited  
 For Profit     Not For Profit  
 Other, describe: \_\_\_\_\_

17. 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 Appendix B - Organization Application for each organization.*

18. 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.)

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

19. Is coverage desired for staff of this organization?  Yes  No

**If yes**, complete Appendix A - Staff Schedule 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

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

21. 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).

22. 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.*

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

**If yes**, for what reason and when? \_\_\_\_\_

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

None required.

\_\_\_\_\_

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

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

27. Are abortions performed on site?  Yes  No

**If yes**, how many within the past 12 months? \_\_\_\_\_

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

**If yes**, please describe: \_\_\_\_\_

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

29. Are medications administered?  Yes  No

**If yes**, by whom? \_\_\_\_\_

30. Do you provide any services over the internet?  Yes  No

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

32. Do you perform any bariatric procedures (*weight loss procedures*)?  Yes  No  
**If yes**, what percentage of your practice is spent on bariatrics? \_\_\_\_\_ %
33. Are physicians' services rendered?  Yes  No  
**If yes**, are the physicians:  private physicians  
 contracted physicians  
 employed physicians
34. Are you accredited by any nationally-recognized accrediting agency?  Yes  No  
**If yes**, please list the agency: \_\_\_\_\_.  
**If no**, explain why the organization has not applied or why the organization is not eligible.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
35. Are you licensed by the NJ Department of Health & Human Resources?  Yes  No
36. List names of employed personnel who are certified in CPR or ALCS.  
 \_\_\_\_\_  
 \_\_\_\_\_
37. Does the organization have a written Quality Assurance/Risk Management Program?  Yes  No
38. Name of designated Risk Manager: \_\_\_\_\_  
 Phone number: (\_\_\_\_\_) \_\_\_\_\_
39. 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
40. Do you sell or lease any medical equipment or other product in connection with your operation?  Yes  No  
**If yes**, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
41. If you lease equipment to others, do you provide maintenance on the equipment?  Yes  No  
**If yes**, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
42. Do you participate as a principal investigator for any clinical trials?  Yes  No  
**If yes**, do you follow FDA-approved protocols?  Yes  No  
**If yes**, please explain on a separate sheet of paper.

**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 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 \_\_\_\_\_  
*Officer of Organization*

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.

**Appendix A - Staff Schedule**

Policy Number: \_\_\_\_\_

Corporation Name: \_\_\_\_\_

Do you anticipate any changes in staff or services provided by this entity in the next year?  Yes  No

**If yes**, please describe: \_\_\_\_\_

List all professional staff including members, partners and shareholders (Physicians, Chiropractors, Dentists, etc.)

Name	Policy # if Princeton insured	License number	Specialty or position	Date of hire	Status		Avg. # hrs. per wk
					Employee	Independent Contactor	

List all Allied Professionals (RN, LPN, CRNA, Nurse Midwife, Techs, Social Worker, Occupational or Physical Therapist, Licensed Counselor, Physician Assist Non-Surg. or Surg., etc.)

Name	Policy # if Princeton insured	License number	Specialty or position	Date of hire	Status		Avg. # hrs. per wk
					Employee	Independent Contactor	

List all other clerical staff

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

*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: \_\_\_\_\_