



746 Alexander Road
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Organization Professional Liability Application

Princeton Insurance
PARTNERSHIP. PREVENTION. PROTECTION.

(800) 334-0588



Organization Professional Liability Application

Issue Quote Renewal Policy # _____

1. Name and mailing address of applicant

2. Name and mailing address of agent

Contact person _____
 Phone (____) _____
 Fax (____) _____

Phone (____) _____
 Fax (____) _____
 E-mail _____

E-mail _____
(Will be used to provide policyholder information only.)

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 | ____ Bariatric |
| ____ Oral | ____ Orthopaedic |
| ____ OB/GYN | ____ Other: _____ |
| ____ Infertility | |
| ____ 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: <i>Financial Statements may be necessary.</i>	_____	_____

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 ad.

16. 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
17. 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: _____
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. How long has the organization been in business? _____ Years _____ Months
20. 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).
21. 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.
22. Has your professional liability insurance ever been cancelled, refused or non-renewed? Yes No
If yes, for what reason and when? _____
23. List the state or municipal licensing requirements with which the facility complies.
 None required.

24. Are radiation or shock therapy, nitrous oxide (or any other anesthetics) administered on site? Yes No
25. If anesthesia machines are used, are they all equipped with fail-safe devices? Yes No
26. Are abortions performed on site? Yes No
If yes, how many within the past 12 months? _____
27. Are procedures in place for patient transfers to another facility in the event of an emergency? Yes No
If yes, please describe: _____

28. Are medications administered? Yes No
If yes, by whom? _____
29. Do you provide any services over the internet? Yes No
30. Do you treat patients at a correctional facility? Yes No
31. Do you perform any bariatric procedures (*weight loss procedures*)? Yes No
If yes, what percentage of your practice is spent on bariatrics? _____ %

32. Are physicians' services rendered? Yes No
If yes, are the physicians: private physicians
 contracted physicians
 employed physicians
33. 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.

34. Are you licensed by the NJ Department of Health & Human Resources? Yes No

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

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

37. Name of designated Risk Manager: _____
 Phone number: (_____) _____

38. 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 Organizational Application for each organization named.

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 conduct clinical trials with experimental drugs? Yes No
If yes, indicate what phases (I, II, III, IV) _____
Copies of your consent forms must be provided if you are conducting phase I or II trials.

43. **Optional Waiver of Consent to Settle 1% discount to premium.** If you chose 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

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.

