Form PL-3000PS Edition 2.07

746 Alexander Road
Princeton, NJ 08540-6305
www.PrincetonInsurance.com

Physician and Surgeons
Professional Liability Application

Princeton Insurance

Partnership. Prevention. Protection.

(800) 334-0588

Physician and Surgeons Professional Liability Application

Section I General Information

1. Name and address of applicant

____
____
____
____

Contact person ______________________________
Phone (____) ______________________________
Fax (____) ______________________________
E-mail ______________________________
(Will be used to provide policyholder information only.)

2. Agency name and address

____
____
____
____

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

3. Birth date __________ 4. Gender: ☐ Male ☐ Female

5. Social Security # ______________________________

6. License # and date for primary practice state ______________________________

7. Type of coverage requested ☐ Claims-Made ☐ Occurrence Plus

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.*

9. 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.)**

10. Type of practice *(Check all that apply)*

☐ Employed Provider ☐ Sole proprietor/Unincorporated ☐ Limited Liability Corporation
☐ Professional Association ☐ Independent Contractor ☐ Principal in a Professional Corporation
☐ Partnership ☐ Other *(describe)* ______________________________

11. Is coverage desired for your professional corporation (PC, PA, LLC, Partnership)? ☐ Yes ☐ No

If yes, name of entity______________________________ Tax ID# ______________

Is this a solo corporation (has no employees, independent contractors or partners)? ☐ Yes ☐ No

Solo corporations must share the limits of liability of the individual.

(Employees and independent contractors are defined as physicians, surgeons, podiatrists, dentists, chiropractors, physician assistants, surgical assistants, residents, nurse anesthetists, nurse midwives, nurse practitioners, nurse surgical assistants, clinical nurse specialists, perfusionists, social workers or psychologists.)

12. Does your corporation have any employees, independent contractors or partners? ☐ Yes ☐ No

If yes, *Appendix B and Appendix C must be completed.*

13. 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							

14. 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						
Total hours worked per week						

Name: ____

15. Name of present insurance carrier ____
Expiration date ____
Type of present policy ***(Attach copy of prior policy)*** ☐ Occurrence Plus (Modified Claims Made)
☐ Occurrence ☐ Claims-Made
Loss runs from all prior carriers are required. If claims made was tail purchased? ☐ Yes ☐ No

16. Previous professional liability insurance carrier(s):

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

17. 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)

18. Have you ever practiced without professional liability coverage? ☐ Yes ☐ No

19. Has your professional liability coverage ever been written with a non-admitted carrier? ☐ Yes ☐ No

20. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? ☐ Yes ☐ No
(If you answered yes to questions 18, 19 or 20 please provide full details on a separate sheet.)

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***

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. 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)*

____

____

____

4. 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)*

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

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

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

Name: ____

8. Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked? ☐ Yes ☐ No

9. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked? ☐ Yes ☐ No

10. Do you have any condition or engage in any activity, or use any substance (including alcohol, drugs or medications) which affects, impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No

11. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? ☐ Yes ☐ No

12. 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

13. 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

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

15. 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.

16. Do you administer Botox injections in any non-clinical settings? ☐ Yes ☐ No

17. **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
    (If you answered yes to any of questions 7 through 16, please explain on a separate sheet, and provide full documentation from any agency involved)

Section III Required Documentation

1. Claim history reports (loss runs) from all prior insurance carriers.
2. Copy of current declarations page from your current insurance carrier.
3. Copy of current New Jersey license.
4. Curriculum vitae.

Section IV Physician/Surgeons Services

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 including all procedures performed using general anesthesia.
    _______% Obstetrics: Number of deliveries per year ________
    _______% Pregnancy terminations:
        ______% first trimester terminations, ______% second trimester terminations

____________ % ASSISTING IN MAJOR SURGERY ON PATIENTS OTHER THAN YOUR OWN

____________ % MINOR SURGERY - performing minor surgery
(Use of general anesthesia for any procedure constitutes major surgery.)

____________ % ASSISTING IN MAJOR SURGERY ONLY ON YOUR OWN PATIENTS

____________ % NO SURGERY - medical practice which may include incising boils and abscesses, removal of superficial skin lesions, suturing minor lacerations.

3. Speciality you currently practice: ____

4. List any procedures that you perform that are not typical to the specialty in which you received your residency or fellowship training:____
____
____

5. List any procedures you perform in the office setting for which you are not privileged to perform in a hospital:(list)_________
____
____
____

6. Have there been any changes in your specialty, classification, or practice activity within the past five years? ☐ Yes ☐ No
If yes, describe the nature of the change(s) on a separate sheet.

7. Have you discontinued performing minor or major surgical procedures within the past five years? ☐ Yes ☐ No
If yes, list the procedure(s) on a separate sheet.

8. Do you read, interpret or diagnose films, slides or specimens taken from patients who reside in states other than your indicated state of practice? ☐ Yes ☐ No
If yes, do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
If yes, provide details on a separate sheet and attach verification of coverage, if applicable.

9. Are you board certified by an AMA-approved specialty board? ☐ Yes ☐ No
Name of specialty board ______________________________ Date of last certification: ______________________________
If no, are you board eligible? ☐ Yes ☐ No
If not board eligible, provide explanation on a separate sheet.

10. Have you ever failed any licensing or Board Certification or recertification examination? ☐ Yes ☐ No
If yes, please provide name(s) of exam(s) and number of times failed on a separate sheet.

11. Medical School: ____ Date of Graduation: ______________________________

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

13. Are you currently an intern, resident or fellow? ☐ Yes ☐ No
If yes, what will be the final date of internship, residency or fellowship?: ______________________________

14. Where did you serve:
Internship: _____________________________ Date of Completion: _______________
Residency: _____________________________ Specialty: __________________________ Date of Completion: _______________
Fellowship: _____________________________ Specialty: __________________________ Date of Completion: _______________

Section V 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.

Signature of Applicant ____ Date _____________________
Print Name of Applicant ____
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.

Name: ______________________________

15. Please check any of the following procedures that you or an allied health provider under your supervision performed in your practice:

- ☐ Abortions
  - ☐ Elective
  - ☐ ≤ 1st Trimester
  - ☐ ≥ 1st Trimester
  - ☐ Prescribe "morning after pill"
- ☐ Acupuncture
  - ☐ Therapeutic
  - ☐ General Anesthetic
- ☐ Anesthesia – non-obstetrical
  - ☐ Conscious Sedation – In Office Setting
  - ☐ General
  - ☐ Spinal
  - ☐ Epidural
- ☐ Anesthesia – obstetrical
  - ☐ General
  - ☐ Spinal
  - ☐ Epidural
- ☐ Angiography
- ☐ Angioplasty/Stents
- ☐ Anti-aging procedures (other than the use of human growth hormone (describe)
  ____
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery (______% of total practice)
  - ☐ On own patients
  - ☐ On patients of others
- ☐ Bariatric surgery, types:
  - ☐ Roux-en-Y
    - ☐ Laproscopic
    - ☐ Other
  - ☐ Banding
    - ☐ Laproscopic
    - ☐ Other
  - ☐ Gastric Restricting, other (describe)
    ____
    ____
- ☐ Bone Fracture Reductions (open)
- ☐ Breast Biopsy
- ☐ Breast Implants (reconstructive)
- ☐ Breast Reduction
- ☐ Bronchoscopy
- ☐ Cardiac (interventional)
  - ☐ Angiography
  - ☐ Angioplasty
  - ☐ Catherization
    - ☐ Swan-Ganz
    - ☐ Right Heart (other than CVP lines)
    - ☐ Left Heart
  - ☐ Cardiac Electrophisiology
  - ☐ Permanent Pacemaker Insertion
- ☐ Chelation therapy *(for other than heavy metal poisoning)*
- ☐ Chemonucleolysis
- ☐ Chemotherapy
- ☐ Circumcision (on other than newborns)
- ☐ Colonoscopy
- ☐ Cosmetic Procedures
  - ☐ Botox Injections
  - ☐ Breast Implants
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Collagen Injections
  - ☐ Cryosurgery (superficial)
  - ☐ Dermabrasion
  - ☐ Eyeliner pigmentation
  - ☐ Fat Transfer
  - ☐ Hair Transplants &or restorations
  - ☐ Laser Hair Removal
  - ☐ Laser Skin Resurfacing
  - ☐ Liposuction
    - ☐ Tumescent
    - ☐ Ultrasound-assisted
    - ☐ <3500cc volume
    - ☐ >3500cc volume
  - ☐ Mesotherapy
  - ☐ Microdermabrasion
  - ☐ Phalloplasty (or penile implant)
  - ☐ Silicone Injections
  - ☐ Other (describe)
    ____
    ____
- ☐ D&C
- ☐ Dermatological Surgery
- ☐ Dermatopathology
- ☐ Dialysis
  - ☐ Hemo
  - ☐ Peritoneal
- ☐ Echocardiography
- ☐ Electrocardiography
- ☐ Emergency Medicine
- ☐ Encephalography
- ☐ Endoscopic Laser Therapy
- ☐ EGD
- ☐ ERCP
- ☐ Exchange Transfers in Newborns
- ☐ Hospitalist Services (_____% of total practice)
- ☐ Hyperbaric Medicine
- ☐ Intensivist Services (_____% of total practice)
- ☐ Interventional Nephrology (list procedures):
  ____
  ____
- ☐ Laparoscopy (list procedures):
  ____
  ____
- ☐ Lithotripsy
- ☐ Laser Surgery
- ☐ Major Surgery (category)
  - ☐ Cardiac
  - ☐ Cardio-vascular
  - ☐ Colorectal
  - ☐ General
  - ☐ Gynecology
  - ☐ Head & Neck
    - ☐ Elective Cosmetic
    - ☐ Laryngology
    - ☐ Otology
    - ☐ Rhinology
  - ☐ Hand
  - ☐ Neuro
  - ☐ Organ Transplant
  - ☐ Ophthalmology
  - ☐ Orthopedic
    - ☐ Joint Replacement
    - ☐ Hip Nailing
    - ☐ Hip Resurfacing
    - ☐ Microsurgery
  - ☐ Plastic
  - ☐ Spine
  - ☐ Thoracic
  - ☐ Vascular
  - ☐ Other(list):
    ____
    ____
- ☐ Mammography
- ☐ Myelography
- ☐ Neonatology
- ☐ Obstetrics
  - ☐ Vaginal Deliveries with Instrumentation
  - ☐ C-Sections
  - ☐ VBAC
- ☐ Osteopathic Manipulative Therapy
- ☐ Pain Management
  - ☐ Cordotomies
  - ☐ Cryoanalgesia
  - ☐ Dorsal Column Stimulator Implants/Reprogramming
  - ☐ Intra-Articular Block (joint injection)
  - ☐ Intradiscal Electrothermal Therapy
  - ☐ Medication Only
  - ☐ Myofascial Trigger Point Injections
  - ☐ Nerve Root Injections
  - ☐ Regenrative Injection Therapy (prolotherapy)
  - ☐ Rhizotomy
  - ☐ Spinal Infusion Pump Refilling/Reprogramming
  - ☐ Spinal Stimulation Programming
  - ☐ Stellate Ganglion Block
  - ☐ Block (spine & non-spine excluding stellate ganglion block)
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Polypectomy
- ☐ pneumoencephalomyelography
- ☐ Prenatal Care
- ☐ Radiology
  - ☐ Therapeutic
  - ☐ Diagnostic
  - ☐ Interventional (list procedures):
    ____
    ____
- ☐ Radiopaque Dye Injections (into blood vessels, lymphatics, sinus tracts or fistulae)
- ☐ Rapid Opiate Detoxification
- ☐ Refractive Surgery
  - ☐ LASIK ☐ PRK
  - ☐ AK ☐ PTK
  - ☐ ICR
- ☐ Sclerotherapy
- ☐ Shock Therapy
- ☐ Sterilization procedures
- ☐ Tonsillectomy/adenoidectomy
- ☐ Transgender surgery and/or hormonal gender conversion
- ☐ Urgent Care Medicine

☐ **None of the above apply to my practice.**

____
(Please initial)

☐ **Other Procedures (List)**

____
____
____

Name: ______________________________

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 ________________________

____
Medical Care Practitioner Signature

____
Print Name of Applicant

____
Home Address*

____
City, State, Zip* Home Phone Number*

____
Witness to Medical Care Practitioner's signature

Date ________________________

____
Corporation

____
Officer

____
Address of Corporation

****This information will only be used for cancellation notification and Extended Reporting offers only.***

Appendix B

Corporation Name: ____

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.

Name: ____

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
   _____ Partnership
   _____ Community Clinic (non-profit)
   _____ Partnership, Limited
   _____ Not for Profit
   _____ Other, describe ____

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.
Attach copies of all advertising materials, stationary, telephone directory yellow pages, handouts and other advertising.