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Allied Healthcare Provider Professional Liability Application

Princeton Insurance
PARTNERSHIP. PREVENTION. PROTECTION.

(800) 334-0588



Allied Healthcare Provider 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.)

Website Address: _____

2. Agency name and address

Phone (____) _____

Fax (____) _____

E-mail _____

Agent's Website Address: _____

3. Birth date _____ 4. Gender: Male Female

5. Social Security # _____

Practice Locations

6. List all locations where you presently work. (Draw a line through any location where you are not practicing, or add additional locations):

Employer/Facility Name	Street	City	State	Zip	Employee or Independent Contractor	Total Hours worked per week*
#1						
#2						
#3						

** Includes patient care, hospital rounds, record keeping, administrative duties, teaching, house calls, nursing home visits, utilization review.*

7. Requested effective date: _____

8. 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.)**

9. Type of coverage requested Claims-Made Occurrence *(only available to certain classes)*

10. Limits of liability requested
 \$1,000,000/\$3,000,000 \$2,000,000/\$4,000,000 *(only available to certain classes)*

11. Do you practice as:

- | | | |
|--|--|---|
| <input type="checkbox"/> Graduate Nurse | <input type="checkbox"/> Optician | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Student Nurse |
| <input type="checkbox"/> Nurse Anesthetist | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> X-Ray Therapist |
| | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> First Nurse Surgical Assistant |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Dental Assistant/Hygienist |
| Specialty _____ | (with Surgical Assist?) <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Licensed Counselor |
| <input type="checkbox"/> Psychiatric Nurse | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Other _____ | |

Name: _____

Corporate Coverage

12. Is coverage desired for your professional corporation? Yes No

If yes, name of entity: _____

Federal Employer Identification Number: _____

13. Does your entity have any employees, independent contractors or partners? Yes No

(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.)

If yes, a separate Appendix A - Staff Schedule and Appendix B - Organization Application must be completed and certificates of insurance and claims histories must be provided for each individual.

If no, solo corporations must share the limits of liability of the individual.

14. List all states in which you are or have ever been licensed or certified.

State	License #	Certificate #	Current Yes/No	State	License #	Certificate #	Current Yes/No

Please explain, in detail, any "Yes" answers on a separate sheet.

15. School of graduation: _____ Degree: _____ Date: _____

16. Provide a detailed description of your principal activity while working:

17. Are you an owner, operator, officer, partner or administrator or do you have a similar capacity for any health care or related services organization? Yes No

18. 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: _____

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

20. Are you currently aware of any investigation being conducted which could impact your license? Yes No

21. 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

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

23. Has your employment ever been terminated? Yes No

24. 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

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

26. Do you practice in any labor and delivery or obstetrical-related areas? Yes No

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

If yes, please explain: _____

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

(If you answered yes to any question 17 through 28, please explain on a separate sheet and provide full documentation from any agency involved.)

29. Have any claims ever been made against you? Yes No
 If yes, complete the following:

Plaintiff name	Incident date	Report date	Status*	Settlement amount/date	Insurance company	Description of claim

* Open, closed without payment, closed with payment.

30. Do you know of any circumstance, acts, errors, or omissions that could possibly result in a professional liability claim against you? Yes No

31. Name of current professional liability insurance carrier _____
 Policy No. _____
 Type of Coverage: Occurrence Claims-Made Expiration date _____

Loss runs from all prior carriers are required. If Claims-Made, was tail purchased? Yes No

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

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

34. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? Yes No

35. Has any company ever cancelled, not renewed or refused coverage? Yes No
 (If you answered yes to questions 32, 33, or 34 please provide full details on a separate sheet.)

36. **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 option waiver applied to your policy? Yes No

Section II 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: _____

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

NOTICE TO 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.

