



746 Alexander Road  
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[www.PrincetonInsurance.com](http://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

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

2. Agency name and address

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

Contact person \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

E-mail \_\_\_\_\_

Agent's website address \_\_\_\_\_

*(Will be used to provide policyholder information only.)*

Website address \_\_\_\_\_

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.)

### Corporate Coverage

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

If yes, name of entity: \_\_\_\_\_

Federal Employer Identification Number: \_\_\_\_\_

11. 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.**

### Practice Locations

12. 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.*

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

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

- 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

Loc. #1		Loc. #2		Loc. #3	
WK	MO	WK	MO	WK	MO

**Total hours worked per week/month**

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

**Loss runs from all prior carriers are required.** If claims made was 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 Assignment of Unearned Premium Form.)

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

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

19. 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 17, 18 or 19 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

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

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

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

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

**(If you answered yes to any of questions 6 through 14, please explain on a separate sheet, and provide full documentation from any agency involved)**

15. Do you participate as a principal investigator for any clinical trials?  Yes  No  
**If yes, do you follow FDA-approved protocols?**  Yes  No

16. **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

**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  
 If you assist in major surgery, do you provide post-operative follow-up care?  Yes  No
- \_\_\_\_\_ % MINOR SURGERY - performing minor surgery  
**(Use of general anesthesia for any procedure constitutes major surgery.)**
- \_\_\_\_\_ % 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:  
 none \_\_\_\_\_
5. List any procedures you perform in the office setting for which you are not privileged to perform in a hospital:(list)  none  
 \_\_\_\_\_
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.

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

- Abortions
  - Elective
  - ≤ 1<sup>st</sup> Trimester
  - ≥ 1<sup>st</sup> 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 Electrophysiology
  - 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
- Chemabrasion
- Collagen Injections
- Cryosurgery (superficial)
- Dermabrasion
- Eyeliner pigmentation
- Fat Transfer
- Hair Transplants &/or restorations
- Laser Hair Removal
- Laser Skin Resurfacing
- Liposuction
  - Tumescant
  - 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
  - Regenerative 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 - 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: \_\_\_\_\_

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

**Appendix B - Organization Application**

1. Name of organization \_\_\_\_\_  
Address \_\_\_\_\_  
Tax ID# \_\_\_\_\_  
Retroactive date \_\_\_\_\_

2. a) Description of operations performed \_\_\_\_\_  
b) Description of services performed \_\_\_\_\_

	<b>Past 12 Months</b>	<b>Projected Next 12 Months</b>
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)*

- |                                                   |                                                        |
|---------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Professional Association | <input type="checkbox"/> Partnership                   |
| <input type="checkbox"/> Corporation              | <input type="checkbox"/> Community Clinic (non-profit) |
| <input type="checkbox"/> Joint Venture            | <input type="checkbox"/> Partnership, Limited          |
| <input type="checkbox"/> For Profit               | <input type="checkbox"/> Not for Profit                |
| <input type="checkbox"/> Other, describe _____    |                                                        |

6. 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)*

7. List members, shareholders, etc.  
\_\_\_\_\_

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

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

10. 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)*

11. 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)*

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

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

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

15. **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

**Complete Appendix B for each organization named. Attach copies of all advertising materials, stationary, telephone directory yellow pages, handouts and other advertising.**