Physician & Surgeon Professional Liability Application

746 Alexander Road, Princeton, NJ 08540-6305 (800) 334-0588 www.PrincetonInsurance.com

Princeton Insurance
a MedPro/Berkshire Hathaway company

Physician and Surgeon Professional Liability Application

Section I General Information

1. Name and mailing 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 (____) _____

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 ☐ Occurrence

8. Indicate professional liability limits desired
☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 (If higher limits are desired, please refer to company.)

9. Requested effective date _____ ☐ Non-binding indication only ☐ Formal quote*
**If a formal quote is requested and it results in a declination, the declination must, by law, be reported to the Department of Insurance.*

10. 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.)**

Practice Locations

11. List all locations where you currently work and/or anticipate working; indicate number of hours worked per week.

Employer/Facility Name	Address	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.*

12. 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/month						

Applicant Name_____

13. Name of present insurance carrier _____
Expiration date _____
Type of present policy (Attach copy of 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

14. Previous professional liability insurance carrier(s)

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

15. 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, the Assignment of Unearned Premium Form must be completed.*)

If you answer yes to questions 16, 17 or 18, please provide full details on a separate sheet.

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

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

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

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

20. Has anyone ever filed a claim against you, regardless of whether the claim was dismissed or a judgment was rendered? *If yes*, please complete a supplemental claims application for each claim. ☐ Yes ☐ No

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. Do you admit patients to any of the above hospital(s)? ☐ Yes ☐ No
If no, please explain your protocol to admit patients to a hospital, if the circumstances would arise, on a separate sheet.

3. 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

Applicant Name_____

4. Are you entering private practice for the first time? ☐ Yes ☐ No

5. Please explain the following gaps if they occurred in the last ten (10) years:
   (a) Gaps greater than one (1) year between your medical school, residency, other training or first time in practice.

   _____

   (b) Gaps greater than six (6) months between practice locations.

   _____

6. To which medical societies or associations do you belong?_____

7. 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:

   _____

   _____

8. Do you treat patients at a correctional facility? ☐ Yes ☐ No
   If yes, (a) average hours per week devoted to treating or reviewing treatment of federal prison inmates: _____ hrs
   (b) average hours per week devoted to treating or reviewing treatment of non-federal prison inmates: _____hrs

9. Are you a team physician for any professional or collegiate athletes? ☐ Yes ☐ No
   If yes, indicate the percentage of your practice devoted to this activity: _____%

10. Do you practice in a nursing home facility? ☐ Yes ☐ No
    If yes, indicate the percentage of your practice devoted to this activity: _____%

11. Do you practice as a Medical Director? ☐ Yes ☐ No
    If yes, what percentage of your practice is devoted to this activity:_____%
    Type and Name of Facility:_____

12. Do you devise or review plant/employer safety standards? ☐ Yes ☐ No
    If yes, what products are manufactured by the company?_____
    Company name and location:_____

If you answer yes to any of questions 14 through 23 please explain on a separate sheet, and provide full documentation from any agency involved.

13. Indicate the number of each of the following who provide services in your office (please exclude yourself):

Physicians	☐☐☐	Nurse Midwives	☐☐☐	Physician Assistants	☐☐☐
Dentists	☐☐☐	Nurse Midwife Assistatnts	☐☐☐	Physician Surgical Assistants	☐☐☐
Aestheticians	☐☐☐	Nurse Practitioners	☐☐☐	Podiatrists	☐☐☐
Case Managers	☐☐☐	Nurse Surgical Assistants	☐☐☐	Pychologists	☐☐☐
CRNAs/RNAs	☐☐☐	Occupational Therapists	☐☐☐	Respiratory Therapists	☐☐☐
Chiropractors	☐☐☐	Perfusionists	☐☐☐		

14. Do you or any member of your practice supervise any healthcare provider that you do not employ or contract with for services? ☐ Yes ☐ No

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

16. Do you anticipate any changes in staff or services provided in the next year? ☐ Yes ☐ No

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

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

19. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics or other controlled substances, etc.) ☐ Yes ☐ No
    If yes, state condition(s) and date(s) and identify your treating physician(s) on a separate sheet. **In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Applicant Name_____

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

21. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

22. Has your professional liability coverage ever been cancelled, restricted, non renewed, declined, or have you withdrawn an application for insurance to avoid declination, or have you ever had an involuntary deductible or surcharge assessed against your policy? ☐ Yes ☐ No

23. 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

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

25. **Optional Waiver of Consent to Settle:** ***1% discount to premium.*** If you choose 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/Surgeon Services

1. 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.

2. Specialty you currently practice _____V_____
3. Are you permanently retired from the practice of clinical medicine? ☐ Yes ☐ No
4. List procedures 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 ☐ none

_____
_____
_____

6. Have there been any changes in your specialty, classification, or practice activity within the past ten years? ☐ Yes ☐ No
Have you discontinued performing minor or major surgical procedures within the past ten years? ☐ Yes ☐ No
If yes, list procedures/activities, reason for and date of change(s) on a separate sheet.

7. Have you performed weight control surgery or prescribed weight control medication within the past ten years? ☐ Yes ☐ No
Do you have ownership or financial interests in a weight control clinic? ☐ Yes ☐ No

8. Do you work in an emergency room on a scheduled basis? ☐ Yes ☐ No
If yes: (a) indicate average number of hours per month devoted to in-hospital emergency room care (not on-call hours) _____
(b) on average how many of the above hours are you working in order to fulfill staff privilege requirements? _____

9. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, telemedicine or internet medicine? ☐ 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.

10. 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 qualified? ☐ Yes ☐ No
    If not board qualified, provide explanation on a separate sheet.

11. 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.

12. Medical school _____ Date of graduation _____

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

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

15. Where did you serve
    Internship _____ Date of completion _____
    Residency _____ Specialty _____ Date of completion _____
    Fellowship _____ Specialty _____ Date of Completion _____

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Applicant Name _____

16. Please check any of the following procedures you will perform:

- ☐ Abdominoplasty - Tummy Tuck
- ☐ Abortions - Elective _____% of total practice
- ☐ Abortions - Therapeutic _____% of total practice
- ☐ Acupuncture -Therapeutic/Local Anesthetic
- ☐ Anesthesia – General/Spinal/Caudal
- ☐ Angiography
- ☐ Angioplasty
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in major surgery - own patients only
- ☐ Assist in major surgery - own & other than own patients
- ☐ Bariatric surgery - Laproscopic
- ☐ Bariatric surgery - Non-Laproscopic
- ☐ Biopsy - Endoscopic
- ☐ Blepharopigmentation _____% of total practice
- ☐ Blepharoplasty - Cosmetic _____% of total practice
- ☐ Blepharoplasty - Reconstruction _____% of total practice
- ☐ Botox _____% of total practice
- ☐ Brachioplasty
- ☐ Breast Implants - Cosmetic _____% of total practice
- ☐ Breast Implants - Reconstruction _____% of total practice
- ☐ Breast Reduction - Cosmetic
- ☐ Bronchoscopy
- ☐ Broncho-esophagology
- ☐ Buttock Implants
- ☐ Calf Implants
- ☐ Cataract Surgery
- ☐ Catheterization - Left Heart
- ☐ Catheterization - Right Heart (other than CVP lines)/Swan Ganz
- ☐ Cheek/Chin/Lip Implants
- ☐ Chelation therapy
- ☐ Chemical Peels - Superficial/Medium
- ☐ Chemical Peels - Deep _____% of total practice
- ☐ Cleft Lip Surgery - Reconstructive
- ☐ Cleft Palate Surgery - Reconstructive
- ☐ Colonoscopy
- ☐ Cryosurgery *(Cervical)*
- ☐ Cryosurgery *(non-external lesions)*
- ☐ D&C
- ☐ Discectomy
  - ☐ Open
  - ☐ Other Than Open
- ☐ Electromagnetic Therapy
- ☐ Electroconvulsive/Shock Therapy
- ☐ Embolization
- ☐ ERCP
- ☐ Face lifts
- ☐ Face lifts Mini *(done with laser)*_____% of total practice
- ☐ Gastrointestinal Endoscopy
- ☐ Gynecology - Major Surgery
- ☐ Hair Transplants - Follicular Unit Transplantations
- ☐ Hair Transplants - Other
- ☐ HVLA on the cervical spine on patients younger than 18 years of age
- ☐ Intrathecal Pumps
- ☐ Kyphoplasty
- ☐ Laparoscopic Cholecystectomy
- ☐ Laparoscopy
- ☐ Laser surgery
- ☐ Laser Therapy *(Endoscopic)*
- ☐ Laser Therapy *(Non-Endoscopic)*
- ☐ Lipoinjection _____% of total practice
- ☐ Liposuction
  - ☐ Other Than Tumescent Technique
  - ☐ Tumescent Technique Only _____% of total practice
- ☐ Lithotripsy
- ☐ Lymphangiography
- ☐ Mammograms
- ☐ Myelography
- ☐ Nerve Blocks
  - ☐ Facet
  - ☐ Lumbar Epidural Steroid
  - ☐ Myofascial
  - ☐ Occipital
  - ☐ Paraspinal/Paravertebral
  - ☐ Peripheral
  - ☐ Sciatic
  - ☐ Triggerpoint Injection
- ☐ Oxidation Therapy
- ☐ Pacemakers - Epicardial
- ☐ Pacemakers - Endocardial
- ☐ Pacemakers - Temporary
- ☐ Peritonescopy
- ☐ Phlebography
- ☐ Pneumoencephalography
- ☐ Polypectomy
- ☐ Prenatal/Gynecological Practice
  - ☐ Prenatal Practice - 1st & 2nd Trimester
  - ☐ Prenatal Practice - to term, no delivery
  - ☐ Prenatal Practice - to term and delivery
  - ☐ Normal Deliveries - total per year _____
  - ☐ Cesarean Deliveries - total per year _____
- ☐ Prolotherapy
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Rectal Ozone Therapy
- ☐ Rhinoplasty _____% of total practice
- ☐ Sigmoidoscopy - 60 cm or less
- ☐ Sigmoidoscopy - Greater than 60 cm
- ☐ Silicone Injections _____% of total practice
- ☐ Skin Flaps/Grafts
  - ☐ Cosmetic _____% of total practice
  - ☐ Reconstruction _____% of total practice
- ☐ Spinal Cord Stimulators
- ☐ Thigh Lift
- ☐ Tubal Ligations
- ☐ Upper GI Endoscopy
- ☐ Vaginal Rejuvenation Procedures *(for cosmetic or sexual enhancement)*
- ☐ Vasectomies - own patients
- ☐ Vasectomies - own & other than your own patients
- ☐ Weight Control Medication _____% of total practice
- ☐ Other Medical Techniques

List Procedures *(do not restate your specialty)*

_____

_____

17. Please indicate the percentage of your total practice performing the following activities:

- ☐☐☐ % Cardiac
- ☐☐☐ % Gynecology
- ☐☐☐ % Hand
- ☐☐☐ % Independent Medical Exams (IME)
- ☐☐☐ % Neurosurgery
- ☐☐☐ % Obstetrics
- ☐☐☐ % Ophthalmology)
- ☐☐☐ % Orthopedic *(including back)*
- ☐☐☐ % Orthopedic *(not including back)*
- ☐☐☐ % Otolaryngology
- ☐☐☐ % Plastic *(cosmetic enhancement only)*
- ☐☐☐ % Plastic *(reconstruction only)*
- ☐☐☐ % Thoracic
- ☐☐☐ % Traumatic
- ☐☐☐ % Urology
- ☐☐☐ % Vascular
- ☐☐☐ % Other Medical *(describe)*

_____

_____

Applicant Name _____

Corporate Coverage - Please complete if you own a professional corporation, professional association, or limited liability corporation

18. Is coverage desired for your professional entity? ☐ Yes ☐ No

If yes, name of entity_____

Federal Employer Identification Number_____

19. Does your entity have any employees, independent contractors or partners that are: ☐ Yes ☐ No

Aestheticians	Nurse Anesthetists	Occupational Therapists	Psychologists	Surgical Assistants
Case Managers	Nurse Midwives	Podiatrists	Residents	
Chiropractors	Nurse Midwife Assistants	Perfusionists	Respiratory Therapists	
Clinical Nurse Specialists	Nurse Practitioners	Physicians	Social Workers	
Dentists	Nurse Surgical Assistants	Physician Assistants	Surgeons	

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

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.

Section V Signature

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 as well as the Company's calculation of the applicable premium should a policy be issued. As a result, I agree to inform the Company of any changes to my practice. I authorize release and exchange of any underwriting or claims information between all prior carriers and 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.

Applicant 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) _____

Applicant Name _____

Assignment of Unearned Premium

1. If the premium payer is other than the named insured, is the unearned premium assigned to the payer?
   - ☐ Yes (Complete remainder of agreement and include both parties' signatures.)
   - ☐ No

Agreement to Assign Unearned Premium

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 current policy term beginning _____ and may do so for subsequent renewals, 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 policy 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 policy 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 and shall remain in effect until the MCP provides written notification of termination to both the Corporation and insurance company which issued the policy.
4. The MCP agrees not to further assign any interest in said professional liability policy without the Corporation's written consent.

Date _____ Date _____

_____ _____

Medical Care Practitioner signature Corporation

_____ _____

Print name of applicant Officer signature

_____ _____

Home address* Print name of officer

_____ _____

City, State, Zip* Home Phone Number* Address of corporation

_____

Witness to Medical Care Practitioner's signature

*This information will only be used for cancellation notification and extended reporting offers only.

Appendix A - Staff Schedule

Entity name _____

List all owners, partners, independent contractors, and employees (physicians, chiropractors, dentists, podiatrists, etc.)

Name	Policy #, if Princeton Insured	License #	Specialty or Position	Date of Hire	Avg # of Hrs Per Week

List all allied professionals (RN, LPN, CRNA, Nurse Midwife, Nurse Midwife Assistant, Tech, Medical Assistant, Social Worker, Occupational, Respiratory or Physical Therapist, Perfusionist, Licensed Counselor, Physician Assistant-Surgery or Non-Surgery, Aesthetician, Case Manager, etc.)

Name	Policy #, if Princeton Insured	License #	Specialty or Position	Date of Hire	Avg # of Hrs Per Week

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# _____

   Effective date _____ Retroactive date _____

   Policy Type: ☐ CM ☐ OCC ☐ OP

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
_____ Other, describe _____

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

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 or 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)*

    _____

    _____

    _____

    _____

Name: _____

14. Are medications administered? ☐ Yes ☐ No

If yes, by whom?

_____

15. Do you perform consultations, render medical services, offer medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, telemedicine or internet medicine? ☐ 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.

16. **Optional Waiver of Consent to Settle** *1% discount to premium.* If you choose 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.

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 as well as the Company's calculation of the applicable premium should a policy be issued. As a result, I agree to inform the Company of any changes to my practice. I authorize release and exchange of any underwriting or claims information between all prior carriers and Princeton Insurance Company.

Signature:_____Date:_____

Print Name:_____