Corporate Entity Application

Entity Name: _____

Phone: _____

Fax: _____

Contact Person: _____

You are applying for coverage under *Conventus'* claims-made policy. If your application is accepted by *Conventus*, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to *Conventus* either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

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www.conventusnj.com

CONVENTUS

Corporate Entity Application

1. Name of Entity: _____
2. Mailing Address for Entity: _____
3. Employer Identification (EIN)# _____
4. Requested Effective Date: _____
5. Retroactive Date: _____
   (If retroactive coverage is required, please complete prior acts application for this entity.)

6. Limits Requested:
   - ☐ $1,000,000/$3,000,000
   - ☐ $2,000,000/$4,000,000
   - ☐ $3,000,000/$5,000,000
   - ☐ $4,000,000/$6,000,000
   - ☐ $5,000,000/$7,000,000

7. Shared limit with Solo Practitioner? ☐ Yes ☐ No
8. Quote for Separate limit requested? ☐ Yes ☐ No
   IF YES, which option?
   a. Quote for OPTION A (Vicarious Liability) ☐ Yes ☐ No
   b. Quote for OPTION B (Non-Vicarious Liability – Defense only) ☐ Yes ☐ No
9. Type of Practice: _____
10. Please indicate the number of people you employ by the following categories:

	Lab or X-Ray technicians		Nurse practitioners*
	Medical assistants		Physicians or surgeons**
	Nurses		Physician assistants*
	Nurse anesthetists*		Surgical assistants*
	Nurse midwives (please note coverage **cannot** be provided for Nurse midwives)		Other (please specify):

* *Non-Physician Health Care Provider Application must be completed for each person in this category.*

** *Physicians and Surgeons Application must be completed for each person in this category.*

11. Are overnight facilities available? ☐ Yes ☐ No (If yes, please attach explanation)
12. Hours of operation: _____
13. Describe the type of organization and ownership. (Check all that apply)
    - ☐ Professional Association
    - ☐ For Profit
    - ☐ Corporation
    - ☐ Joint Venture
    - ☐ Partnership
    - ☐ Community Clinic
    - ☐ Not for Profit
    - ☐ Limited Liability Corporation
    - ☐ Partnership, Limited
    - ☐ Other, please describe: _____

14. List all physicians practicing within this group or corporation: (attach additional sheet, if necessary)

Name	License Number	Specialty	How long with group? Months/Years	Owner? Employee? Contractor?	Average# of hours worked per week?	Conventus Insured? If NO, please provide poof of coverage

15. How long has the organization been in business? _____ Years _____ Months

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

17. Has a claim ever been made against the Entity regardless of whether the claim was dismissed or a judgment rendered? ☐ Yes ☐ No
(If yes, please complete Supplemental Claims Information sheet)

18. Name of current professional liability insurance carrier: _____
(Must attach a copy of the declarations page or certificate of insurance showing: retro date, limits of liability, policy period and any restrictive endorsements)

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

20. Are procedures in place for patient transfer to another facility in the event of an emergency? ☐ Yes ☐ No
(If Yes, please describe) _____

21. Are medications administered? ☐ Yes ☐ No
(If Yes, by whom?) _____

22. Are there subsidiaries that are to be included in this coverage? ☐ Yes ☐ No
(If yes, please complete an application for each subsidiary.)

23. If corporation is purchasing coverage for employed or contracted physicians, is the corporation requesting that they assign rights to premium and surplus contribution? ☐ Yes ☐ No
[If yes, then complete Assignment of Unearned Premium (Appendix A) and Assignment of Surplus Contribution rights (Appendix B)]

Signature

I understand that no coverage will be bound until after Conventus Inter-Insurance Exchange has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of Conventus' intent to provide coverage. If coverage is declined by Conventus, any advance payment will be promptly returned.

I understand that, if granted prior acts coverage by Conventus, no insurance will be provided for any claim (or incident that the insured has reason to believe might result in a claim) known to the insured at the effective date that has, or has not, been reported to another insurance carrier prior to the effective date.

I hereby declare and warrant that the information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts, or circumstances that might affect the underwriter's judgment when considering this application or that might be material to the underwriter's agreement to issue this insurance. I agree that if the information on this application changes between the date of this application and the effective date of insurance, I will immediately notify Conventus of such changes and Conventus reserves the right to withdraw or modify any outstanding quotations and/or any authorization or agreement to bind the insurance.

I understand that, in underwriting this insurance, Conventus has relied upon the information contained in this application together with any related information submitted in support of the application. I understand that if Conventus accepts this application and agrees to issue a policy, this application shall be incorporated into and become a part of the policy as issued. If I have received assistance in completing this application, I acknowledge that I have reviewed the application and certified the accuracy of all information completed on my behalf.

I authorize the release of any underwriting, credentialing and/or claim information from (and release from any and all liability for the provision of information) all prior and current insurers, all professional societies or associations, any state licensing authority, any hospitals, or any credentialing agency to Conventus and its subsidiaries, or agents, or Attorney-in-Fact.

Signature of Owner/Applicant: _____ Date: _____

Conventus reserves the right to reject any application that does not meet its underwriting standards.

Statement Declining to Purchase Separate Corporate Coverage

I understand my options to purchase separate corporate coverage for my entity and I will be declining this offer at this time.

Signature: _____ Date: _____

NOTICE TO NEW JERSEY 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.