



ENTITY LIABILITY APPLICATION

Legal Name of Entity _____ Tax ID Number _____

Entity Business Address (include city, state, zip) _____

Phone _____ Fax _____ E-mail Address _____

Attach Copy of Date Stamped Articles of Incorporation or Partnership Agreement

Desired coverage effective date: _____ 12:01 a.m.

Desired coverage type:

- CLAIMS-MADE **With Prior Acts Coverage.** Retroactive date used by your existing carrier: _____ 12:01 a.m.
Complete prior acts application.
- CLAIMS-MADE **Without Prior Acts Coverage** (decline or do not need retroactive coverage). The retroactive date on the policy applied for will be the same as the effective date of coverage.
- CLAIMS-MADE-PLUS **Includes extended reporting endorsement (tail coverage).**

Entity Type

- Professional Corporation
- Business Corporation
- Limited Liability Corporation
- Partnership
- Professional Association

- Joint Venture
- Other

Description of Operations

- Private doctor's office
- Doctor's office with diagnostic equipment
- Outpatient Surgery Urgent Care Facility
- Physician owned and operated lab –owner use only
- Physician owned and operated lab –used by other than doctor/owner patients
- Other

Are there any services or business operations conducted outside of New Jersey? Yes No

If yes, describe: _____

How many physicians and/or surgeons are in your group? _____ How many are applying to HPIX? _____

ALLIED EMPLOYEE COVERAGE

Each Entity applying for coverage should complete the staff schedule. The staff schedule should include all professional and allied staff.

Does your entity employ any allied professionals? Yes No

Allied employee(s) applying for coverage with HPIX must complete an allied employee application, provide proof current professional liability coverage and ten(10) year claim history. Certified Registered Nurse Anesthetist, Physicians Assistant and Nurse Midwife allied employee not applying for coverage must submit proof of their professional liability coverage.

