

2. Provide the following information:

Name of Institution

City

State

Date Completed

Undergraduate: _____

Nurse Midwife Training: _____

Did you receive a degree for your Nurse Midwife training? YES NO

3. List all locations and dates where you have practiced in the last 10 years:

Practice Name	City/State	From	To

4. Are you certified by the American College of Nurse Midwives?

YES NO

PRACTICE INFORMATION

5. Do you practice as a(n):

Private Solo Practice

Employee of a Clinic

Private Group Practice

Owner of a Birthing Center

Employee of OB/GYN Group

Employee of a Birthing Center

Independent Contractor of OB/GYN Group

Employee of a Hospital

6. List all hospitals and birthing centers where you have staff privileges:

<u>Facility</u>	<u>City & State</u>	<u>% of Practice</u>	<u>Type of Privilege</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Indicate the number of medical professionals you employ, contract with or supervise.

<u>Profession</u>	<u>Employed</u>	<u>Contracted</u>	<u>Supervised</u>
Certified Nurse Midwife			
Nurse Midwife			
Midwife			
Nurse Practitioner			
Registered Nurse			
Licensed Practical Nurse			
Doula			
Other: _____			

SPECIFICS OF PRACTICE/PROCEDURES

8. Average weekly practice hours? _____

9. Average number of patients seen per week? _____

10. How many patients seen are unrelated to pregnancy? _____

11. Are patients screened prior to delivery and determined to be low risk for complications?

YES NO



12. What is the protocol if a patient is determined to be other than low risk? _____

13. What percentage of your deliveries are done in the following locations:

	Past 12 Months	Next 12 Months
Hospital	_____	_____
Birth Center	_____	_____
Home	_____	_____
Other: _____	_____	_____

Provide the annual number of procedures:

	Past 12 Months	Next 12 Months
Vaginal Deliveries	_____	_____
Scheduled Caesarian Sections	_____	_____
Emergency Caesarian Section	_____	_____
VBAC's	_____	_____
Multiple Births	_____	_____
Patients transferred after delivery	_____	_____

14. If involved with C-Section deliveries, what role do you perform:

- Observe
- Assist
- Second Assist
- Other (describe) _____

15. Do you induce labor? YES NO

If yes, with what: _____

16. Do you use epidurals? YES NO

If yes, list administrators: _____

17. Is a physician present during all deliveries? *If no, please provide explanation.* YES NO

18. Is your supervising physician certified by the American Board of Obstetrics and Gynecology? YES NO

19. Are any physicians during any of your shifts:

On-call YES NO

On-site YES NO

20. Are you a clinical preceptor for midwifery students? YES NO

If yes, for how many students per year? _____

PRIOR POLICY AND LOSS INFORMATION – Questions 21-36 provide details for all “YES” answers

21. Has your license to practice midwifery ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? YES NO

22. Has your midwifery certification or membership in any medical society or association ever been refused, suspended, revoked, or voluntarily surrendered? YES NO

23. Have your hospital or birthing center privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? YES NO



24. Have you ever been charged with, or convicted of a crime other than minor traffic violations? YES NO
25. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? YES NO
26. Has any fee or professional relations complaints been registered against you with your medical association, hospital, birthing center, or a state licensing authority? YES NO

27. Provide the following information pertaining to your past 5 years of professional liability insurance coverage:

<u>Carrier</u>	<u>Policy Period</u>	<u>Policy Limits</u>	<u>Deductible</u>	<u>Claims Made? (Y/N)</u>	<u>Retro Date</u>

28. Do you currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? If yes, identity _____ YES NO
29. Have you ever practiced without professional liability insurance? YES NO
30. Do you have professional liability insurance for work you do elsewhere? If yes, please explain on page 5. YES NO
31. Have you ever had any insurance company decline, cancel, rescind, or non-renew any professional liability insurance policy? YES NO
32. Have you ever been involved in any professional liability claim or suit, either directly or indirectly? YES NO
33. Are you aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? YES NO
34. Are you aware of any request for medical records by a patient or his/her attorney which might result in a claim? YES NO
35. Are you aware of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission, or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result notice, or attorney contact? YES NO
36. Have all circumstances that might reasonably lead to a claim or suit, even if you believe them to be without merit, been reported to your current or prior professional liability company? **Indicate N/A if you are not aware of any such circumstances** . If yes, how many? ____ please complete a supplemental claims form for each. YES NO N/A

REQUESTED COVERAGE

(NOTE: The Company may not offer or quote requested coverage)

Requested Effective Date: _____

Requested Retroactive Date: _____

Requested Limits of Liability

Requested Deductible

- ___ \$100,000/\$300,000
- ___ \$200,000/\$600,000
- ___ \$250,000/\$750,000
- ___ \$500,000/\$1,500,000
- ___ \$1,000,000/\$3,000,000
- ___ \$2,050,000/ \$6,150,000 (VA only)

- ___ \$5,000
- ___ \$7,500
- ___ \$10,000
- ___ \$25,000
- ___ \$50,000
- ___ Other \$ _____



SUPPLEMENTAL INFORMATION

Use this page to as needed to address questions referenced within the application or to provide information you deem pertinent to our review of your application

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

- I have no known losses or claims that have not been reported to my prior insurance carrier or any other source from which payment might be made;
- I have no knowledge of acts, omissions or circumstances that relate to a professional service which could reasonably result in a claim, that has not been reported to a prior insurance carrier;
- I have no knowledge of any request for medical records by a patient or their attorney which might result in a claim;
- I have no knowledge or information relating to service or services on a Board which might result in a claim; and
- I have no knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result, or attorney contact.

My signature on page 7 below confirms the above statements unless otherwise noted.

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.



The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material fact.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

Applicants Signature: _____ Date: _____

Agent/Broker Name: _____



SUPPLEMENTAL CLAIM/ INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: _____ Age: _____ Sex: _____

Incident Claim

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

Additional Defendants: _____

What is the present condition of the patient? _____

STATUS OF CLAIM

Suit threatened, no action taken

Suit filed but dropped by claimant

Summary judgment in your favor

Suit settled out of court

Date claim paid: _____

Amount paid: \$ _____

Did you want to settle? Yes No

Court outcome in YOUR favor:

Jury verdict

Directed verdict

Court outcome in favor of plaintiff:

Jury verdict

Directed verdict

Amount of loss payment: \$ _____

Unresolved/Open

Awaiting mediation

Awaiting court action

Reserve amount: \$ _____

Name and address of the attorney assigned to your case: _____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes:

No:

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

Signature: _____

Date: _____

Printed Name: _____

