PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

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APPLICATION FOR CERTIFIED NURSE MIDWIFE'S PROFESSIONAL LIABILITY INSURANCE
Limits of Liability: $500,000 Per Occurrence / $1,500,000 Per Annual Aggregate

POLICIES ARE ISSUED ON AN ANNUAL BASIS UNLESS OTHERWISE SPECIFIED AND APPROVED BY THE JUA
COVERAGE CANNOT BEGIN PRIOR TO APPLICATION AND PREMIUM RECEIPT BY THE JUA

Applicant's Name: ☐ **CNM**

First Name Middle Name Last Name

Coverage Requested:	☐ **Occurrence** ☐ **Claims-Made**	**Requested Effective Date:**	
		Requested Retroactive Date:	

Coverage Period if less than 1 year (short-term policy): ***From:*** ***To:***

Reason for short-term policy:

Part I - General Information

Home Address: _____
Number and Street City State Zip

Principal Business Address: _____
Number and Street City State Zip

Preferred Mailing Address: ☐ Home ☐ Business ☐ Other (Use an attachment to list and explain)

Business Phone: (____) _____ **Home Phone:** (____) _____

Business Fax: (____) _____ **E-mail Address:** _____

Date of Birth: _____

PA Medical License No.: _____

Part II – Broker Information: (If this is being submitted by an insurance broker):

Broker: _____ **Contact Person:** _____

Phone: (____) _____ **Fax No.** (____) _____ **E-Mail Address:** _____

Address: _____
Number and Street City State Zip

EIN or SS No.: (If "new" to JUA) _____

Part III – Coverage Information:

List ALL Prior Insurers for the last 10 years – include all places of employment: (attach separate list if necessary)

Carrier or Self-Insurer	**Policy Number**	**Coverage Dates (Month, Day & Year) Eff. Exp.**	**Coverage Type (Occurrence or Claims-Made)**	**Retroactive Date (if Claims-Made)**	**Tail Coverage Purchased?**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**

If any of the above policies are still in force, explain why coverage is requested from the JUA:

_____

Explain any gaps in coverage in the past 8 years including any period directly preceding JUA coverage:

_____

Explain why tail coverage was not purchased for any claims-made policy listed above:

_____

Attach a copy of your current Declarations, current CV (initialed and dated) and Policy History / Claim History Reports from each of the above carriers or self-insurers plus Mcare.
You need to contact each of your current or prior carriers and request they send you these reports. They are required to provide these reports to you if you request them. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if you have had no claims.

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

Claims or Suits:
Have any claims been made or suits brought against you during the past 10 years as a result of professional services rendered? (Regardless of whether the claim was dismissed or a judgment rendered) ☐ Yes ☐ No If yes, attach a description of all claims made or suits brought including the date and status.

Medical Incidents:
Are you aware of any medical incidents which occurred during one of the claims-made policies *for which a claim has not yet been made*? ☐ Yes ☐ No If yes, attach a complete description of the incidents including the date and status.

Never Events:
Have any claims been made or suits brought against you for an incident where the patient's medical insurance or Medicare refused to pay because it was on their "never event" list? ☐ Yes ☐ No If yes, attach a description of the incident including the date and status.

Part IV – Locations: (AT LEAST ONE LOCATION MUST BE LISTED – all locations must total 100%):

A. List ALL locations and hospitals at which you will practice during the policy period (even if outside Pennsylvania). If you also attend births in private homes, list all counties in which you provide those services. Base percentage of practice on the number of patients. Use additional pages if needed.

Practice Locations:

1. _____ _____
Suite Number & Street City State County Zip Phone % of Practice

2. _____ _____
Suite Number & Street City State County Zip Phone % of Practice

3 _____ _____
Suite Number & Street City State County Zip Phone % of Practice

Hospital Locations:

1. _____ _____
Name of Hospital City State County Type of Privileges % of Practice

2. _____ _____
Name of Hospital City State County Type of Privileges % of Practice

B. If any of the locations listed in A. above are NOT to be covered by the JUA insurance, please list location names and addresses below. Use additional pages if needed. **No coverage will be provided for locations outside of Pennsylvania.**

_____

C. History:
List other locations and hospitals at which you have practiced in the past 10 years:

1. _____ _____
Address or Name of Hospital City State County Dates of practice

2. _____ _____
Address or Name of Hospital City State County Dates of practice

Part V – Educational Background (attach separate sheet if needed to fully describe)

Nursing School: _____ **Year Graduated:** _____

Location of School: _____ **Degree:** _____
City State Country

Additional Training:

_____
Name of School or Hospital City State

From _____ to _____ Type of Training Completed: _____
Month/Year Month/Year

Part VI – Licenses

Have you ever been licensed in a state other than Pennsylvania? ☐ Yes ☐ No If Yes:

State	License Number	Date Received	Currently Active?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

Part VII – Rating Information

1. How many hours per week are generally spent in the practice of your medical profession? _____
If only a portion of your practice is to be covered by this insurance, how many hours per week are generally spent in the portion of your practice to be covered? _____

2. Will you be performing professional activities that will be covered by another professional liability policy?
☐ Yes ☐ No If yes: Practice description and location: _____
Name of insurance company and policy number: _____

3. Is there a formal emergency transfer procedure in place where you practice? ☐ Yes ☐ No

4. How far is the nearest emergency care facility? Miles_____ Time _____

5. Do you consult or contact an Obstetrician if there are complications? ☐ Yes ☐ No

6. Do you accept patients that are or have been diagnosed with the following (check all that apply)

☐ Diabetes ☐ Hypertension
☐ Alcohol /Drug Addiction ☐ Obesity
☐ Heart Disease ☐ Cancer, please describe _____
☐ Sexually Transmitted Disease ☐ Asthma
☐ Carrying Multiples
☐ Other elevated risk conditions, describe: _____

7. With respect to the *above questions* have any aspects of your practice changed in the past **2 years**? ☐ Yes ☐ No
If yes, give details: _____

8. **Procedures and Practices** *(at least one column must be checked for each item on the list)*
In **Column A** check the box for all of those items applicable to the practice for which you are applying for JUA coverage.
In **Column B** check the box for all of those that applied to your practice at any time **During the Last 10 Years**.
If neither Column A or B apply, check the box in the column labeled **No**

Col. A	Col. B	No		Col A	Col. B	No	
☐	☐	☐	Deliver babies - Hospital	☐	☐	☐	Routine Gynecological Care
☐	☐	☐	Deliver babies – Birth Centers	☐	☐	☐	Pap Smears
☐	☐	☐	Deliver babies – Private Homes	☐	☐	☐	Breast Exams
☐	☐	☐	Normal Obstetrical Deliveries Only	☐	☐	☐	Pelvic Exams
☐	☐	☐	Assist in Caesarian Sections	☐	☐	☐	Prenatal care through 1st trimester
☐	☐	☐	Perform Epidurals	☐	☐	☐	Prenatal care through 2nd trimester
☐	☐	☐	Perform Episiotomies	☐	☐	☐	Prenatal care through 3rd trimester
☐	☐	☐	Post Partum Care				

Use this space to provide any additional details, explanations or information about the above procedures and practices:

Part VIII – Practice Organization

1. Please check all the boxes that describe the practice for which you want insurance:

☐ A private independent midwifery solo practice ☐ Owner of a freestanding Birth Center
☐ A private independent group midwifery practice ☐ Employee of a freestanding Birth Center
☐ Employee of OB/GYN Medical practice ☐ Employee of a Hospital
☐ Government employee ☐ Home Births
☐ Other, please describe _____

2. Name of corporation, partnership or employer: _____

3. Do you wish coverage for your Professional Corporation or Partnership? ☐ Yes ☐ No
If yes, a separate corporation/partnership application is required for each entity.
If no, is the corporation/partnership insured elsewhere? ☐ Yes ☐ No

Applicant's Signature (all pages must be signed): _____ _____
(Name) (date)

Part IX – Additional Professional Information

1. Do you maintain or are you a member of any website, blog or other internet, electronic or social media network that is related to the practice for which you are applying for JUA coverage? ☐ Yes ☐ No
   If yes, provide names of sites: _____
   _____
2. Have your staff privileges, license to practice, participation in any Medicaid or Medicare program, or ability to prescribe drugs ever been revoked, suspended, placed on probation, voluntarily surrendered or subject to reprimand or fine? ☐ Yes ☐ No
   If yes, give details: _____
   _____
3. Have you ever been charged or convicted of any crime, or are you currently under investigation for a criminal act, other than minor traffic violations? ☐ Yes ☐ No
   If yes, give details: _____
   _____
4. Has a complaint against you ever been submitted to the Board of Medical Examiners or are you currently under investigation by any regulatory agency? ☐ Yes ☐ No
   If yes, give details: _____
   _____

ORDERING MCARE LOSS RUNS/CLAIM HISTORIES

For facilities requesting their own information, requests are to be on the facility's letterhead and include position title with signature of person submitting request. Include the claim history date range or "all history" for a full report. Also include the name, email and/or address where the claim history is to be sent.

For individual health care providers, the request must be signed by the individual and include the individual's name and PA license number. Indicate the claim history date range or "all history" for a full report. Indicate the name of the person or entity authorized to receive the claim history and the email and/or address where the claim history is to be sent.

Requests are to be sent to Mcare by U.S. Mail, fax or email:

Mailing Address (for USPS first class mail):
Mcare
Claims Administration Division
P.O. Box 12030
Harrisburg, PA 17108-2030

Fax: (717) 787-0651 Email: RA-IN-CLAIMCOVERAGEINFO@pa.gov

If you have any questions regarding Mcare loss runs/claim histories call Mcare at (717) 783-3770 or email RA-IN-CLAIMCOVERAGEINFO@pa.gov.

APPLICATION CERTIFICATION

I certify that I will not accept insurance from the JUA if I am able to obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers.

I do hereby warrant the truth of any statements and answers on this application or any materials that accompany this application and that I have not withheld any information with is calculated to influence the judgment of the JUA in considering this application.

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's Signature (all pages must be signed): _____ _____
(Name) (date)

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

Supplemental Claims Information Form
Complete one form for each claim. Make additional copies of this form as needed.

Applicant's Name: _____
(First) (Middle) (Last)

License Number: _____

Claimant's Name: _____
(First) (Middle) (Last)

Incident Date: _____
(Month, Day and Year)

Date Reported: _____
(Month, Day and Year)

Location Where Incident or Alleged Injury Occurred: _____

Carrier Name: _____

Policy Number: _____ Effective Date: _____

Status (check all that apply):

☐ Open ☐ Closed Date Closed: _____

☐ Settlement ☐ Judgment ☐ Dismissed

Amount of Indemnity Payment (if any): $_____

Description of Claim:

_____

_____

_____

_____

_____

_____

_____

_____