PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

1777 Sentry Parkway West, VEVA 14, Suite 300, Blue Bell, PA 19422
(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com

APPLICATION FOR BIRTH CENTER 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:
Legal Name of Birth Center

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

Principal Office Address:

_____
Number and Street City County State Zip

Business Phone: (___) _____ **Mcare License Number:** _____

Business Fax: (___) _____ **EIN:** _____

E-mail Address: _____ **Web Site:** _____

IS THE ABOVE ADDRESS THE ONLY LOCATION? ☐ **YES** ☐ **NO** **If no, attach a separate page listing all other locations including name, address, city, county, state and zip code for each location.**

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

If "new" to JUA:

EIN or SS No: _____

PART III – COVERAGE INFORMATION

List ALL Prior Insurers for the last 10 years (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**
			☐ **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 copies of your current Declarations, Certificate of Licensure, most recent full state licensure survey 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 the birth center 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 the birth center for an incident where the patient's medical insurance or Medicare refused to pay because it was on their preventable serious adverse event or "never event" list?

☐ Yes ☐ No If yes, attach a description of the incident including the date and status.

PART IV – BUSINESS ORGANIZATION

1. Type of Legal Entity: ☐ Corporation ☐ Association ☐ Partnership ☐ Sole Proprietorship
   (check all that apply) ☐ Profit ☐ Non-Profit ☐ Other (describe): _____
2. Years legal entity has been in operation: _____
3. Years owned by current owners: _____
4. Does the entity utilize any fictitious or "dba" names? ☐ Yes ☐ No If yes, please list on the line below:
   _____
5. Are these fictitious or "dba" names registered with the Pennsylvania Department of State?
   ☐ Yes ☐ No ☐ N/A (Not Applicable; the entity does not utilize any fictitious or "dba" names)
   If **No**, explain: _____

Please submit:

- **A copy of the birth center's current Certificate of Licensure issued by the Pennsylvania Department of Health.**
- **A copy of the most recent full state licensure survey including Plan of Correction for any discrepancies. This should not be a draft copy.**

PART V - OFFICERS, MEMBERS, PRINCIPALS OR PARTNERS

1. List the names of all health care providers who are Officers, Members, Principals or Partners of the birth center that is applying for JUA coverage. Attach a separate list if necessary.
   Note: Physicians, Podiatrists or Certified Nurse Midwives that are also seeking individual medical professional liability coverage with the JUA must complete a separate JUA application appropriate to their specialty.

Name	License Number	Specialty	PA JUA Policy Number	Name of Company if **NOT** Insured by JUA

2. List any non-medical professionals who are Officers, Members, Principals or Partners of the birth center:

Name	Position/Title	Occupation

3. Does any health care provider who is an Officer, Member, Principal or Partners of the birth center practice in any state other than PA? ☐ Yes ☐ No If yes, complete a. through c. below for each. Attach a separate page if necessary.
   a. Name of Principal _____
   b. Name of Other State _____
   c. Percent of Patient Care in Pennsylvania _____%

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

PART VI – STAFFING – EMPLOYEES OR INDEPENDENT CONTRACTORS

1. List the names of all **Physicians, Podiatrists or Certified Nurse Midwives** that are employees or contractors of the birth center that is applying for JUA coverage. Attach a separate list if necessary.
   Note: Physicians, Podiatrists or Certified Nurse Midwives that are also seeking individual medical professional liability coverage with the JUA must complete a separate JUA application appropriate to their specialty.

Name	License Number	Specialty	Employee or Contractor	PA JUA Policy Number	Name of Company if **NOT** Insured by JUA

2. Check the box next to each of the types of Health Care Professionals listed below that are employees or contractors of the birth center that is applying for JUA coverage. Provide numbers of each. Attach a separate list if necessary.
   ☐ Nurse Practitioners Number: _____ ☐ Physician Assistants Number: _____
   ☐ Registered Nurses (RNs) Number: _____ ☐ Licensed Practical Nurses (LPNs) Number: _____
   ☐ Other (describe) _____ Number: _____
   ☐ Other (describe) _____ Number: _____
3. Does the birth center obtain evidence of medical professional liability insurance in force for all physicians, podiatrists, certified nurse midwives and other health care professionals listed in 1. and 2. above? ☐ Yes ☐ No
   If no, explain: _____
4. How often is the evidence of insurance verified? ☐ Annually ☐ Other (describe) _____
5. Is there an employee orientation program? ☐ Yes ☐ No
6. Is in-service training conducted? ☐ Yes ☐ No If yes, what is the frequency? _____
7. Who is authorized to administer drugs and medications? _____
8. Is there a Physician Director of Medical Affairs? ☐ Yes ☐ No If yes, provide full name and Pennsylvania medical license number. If no, explain: _____
   Is this physician a Board Certified: Obstetrician ☐ Yes ☐ No or Pediatrician ☐ Yes ☐ No
9. Is there a Director of Midwifery Services? ☐ Yes ☐ No If yes, provide full name and Pennsylvania midwife license number. If no, explain: _____
10. Does the birth center allow physicians, podiatrists, certified nurse midwives or other types of health care professionals who are **NOT** employees or contractors to use its facilities to provide health care professional services? ☐ Yes ☐ No
    If yes, provide a list by specialty, number and describe services provided. Attach a separate page if necessary.
    _____
    _____

PART VII – SERVICES / OPERATIONS

1. What types of services does the birth center provide? Check all that apply:
   ☐ Prenatal Care ☐ Intrapartum Care
   ☐ Postpartum Care ☐ Well Woman Care
   ☐ Other (describe): _____
2. Do you accept patients that are or have been diagnosed with the following (check all that apply):
   ☐ Diabetes ☐ Hypertension ☐ Heart Disease
   ☐ Carrying Multiples ☐ Obesity ☐ Asthma
   ☐ Sexually Transmitted Disease ☐ Alcohol / Drug Addiction ☐ Cancer
   ☐ Other elevated risk conditions, describe: _____

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

PART VII – SERVICES / OPERATIONS (continued)

3. Are there instances where patients with certain conditions are not accepted by the birth center? ☐ Yes ☐ No
   If yes, describe. Attach a separate sheet if necessary. _____
   _____
   Are these patients referred elsewhere? ☐ Yes ☐ No
4. Does the birth center consult or contact an Obstetrician if there are complications or emergencies? ☐ Yes ☐ No
   If no, explain: _____
5. Does the birth center have current written transfer procedures in place for the mother and infant should complications or emergencies arise? ☐ Yes ☐ No
6. How far is the nearest emergency care facility? Miles _____ Time _____
7. Does the birth center have written service agreements with (check all that apply):
   ☐ Primary Emergency Transportation Service ☐ Alternate Emergency Transportation Service
   ☐ OB/GYN Physician or Group ☐ Neonatology Physician or Group
   ☐ Hospital with NICU ☐ Other (describe): _____
8. Is there an internal infection control plan? ☐ Yes ☐ No
9. Is the facility currently accredited by the Commission for the Accreditation of Birth Centers (CABC)? ☐ Yes ☐ No

PART VIII – ADDITIONAL PROFESSIONAL INFORMATION

1. Does the birth center maintain a website, blog or other internet, electronic or social media network presence?
   ☐ Yes ☐ No If yes, provide names of sites: _____
   _____
2. Has any enforcement action ever been taken against the birth center, including but not limited to: limitation or ban on admissions or services; license revoked or suspended; refusal to renew license; provisional license; or civil money penalty? ☐ Yes ☐ No
   If yes, provide date, description of action taken and name of authority assessing the enforcement action. Attach a separate page if necessary. Provide copies of any correspondence regarding the enforcement action.
   _____
   _____
3. Has a complaint against the birth center ever been submitted to the Pennsylvania Department of Health or is the birth center currently under investigation by any regulatory agency? ☐ Yes ☐ No
   If yes, give details: _____
   _____

I certify that I am authorized to act on behalf of the Insured.

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 which 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)

GENERAL INFORMATION

We write **only** *professional liability* coverage (*general liability* is *not covered*), nor do we write any excess coverage (coverage that is over the Mcare).

Coverage is provided only for liability incurred by the Insured birth center for patient injury arising out of the rendering of or failure to render professional health care services by a person for whose acts or omissions the Insured birth center is legally responsible, subject to the terms and conditions of the JUA policy.

We provide coverage only for the birth center (not any holding company or other parent company). No additional insureds will be added. The name of the Insured will be the name of the birth center as shown on the Certificate of Licensure.

It is critical that the type of claim be indicated on loss history reports (professional liability separated from general liability; birth center professional separated from individual health care provider professional).

We require a **separate application for each physician, podiatrist and certified nurse midwife to be covered.**

We require a separate application for each birth center.

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.

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

Supplemental Claims Information Form

Complete one form for each claim. Make additional copies of this form as needed.

Entity Name: _____

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:

_____

_____

_____

_____

_____

_____

_____

_____