GenStar

RENEWAL APPLICATION

PROFESSIONAL LIABILITY

CERTIFIED NURSE MIDWIVES
Claims-Made and Reported Coverage

Please complete this application and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

INSTRUCTIONS TO THE APPLICANT:

- You must provide a fully completed application, signed and dated by you within 45 days of the desired effective date of coverage.
- Appropriate Supplementary Applications, Claim Information Supplement(s) and additional documentation must also be completed as needed.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.

I. GENERAL INFORMATION

1	Applicant Name:		
	"Doing business as" (d/b/a) names used? If **YES**, specify:		☐ Yes ☐ No
2	Name of any Professional Corporation, Partnership or Association of which the applicant is an owner and the percentage of ownership:	Name:	%
		Name:	%
3	Mailing Address:		
	City:	County:	
	State:	ZIP:	
4	Primary Office Address:	Telephone No.:	
	City:	County:	
	State:	ZIP:	
	Do you have more than one practice location? If **YES**, please provide the following for each location: location address, hours of operation, procedures performed, number of years at location:		☐ Yes ☐ No
5	E-mail:	Web Site:	
6	Home Address:		
	City:	County: i	
	State:	ZIP:	
7	Are you in active, full-time practice? If, **NO**, describe in the Additional Information section or on a separate sheet.		☐ Yes ☐ No

II. TRAINING and EDUCATION

1	Undergraduate:	From: To:		
	Degree:	Major:		
2	Nurse Midwife Training completed at:			
3	Date:	Degree: ☐ Yes ☐ No		
4	License Number:	State:		
	State	License Number	License Issue Date	License Expiration Date
5	Are you certified by the American College of Nurse Midwives?			☐ Yes ☐ No
6	Are you currently a member in good standing with the ACNM? If **NO**, explain: jjpjpjjpj			☐ Yes ☐ No

III. PRACTICE HISTORY AND DESCRIPTION

1	List all locations where you have practiced in the past ten (10) years:				
	Street Address & City	County	State	From	To
2	List all Hospitals and Birthing Centers where you have staff privileges:				
	Facility	City & State	% of Practice	Type of Privilege	

3	Do you practice as:					
	☐	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 with OB/GYN Group	☐	Employee of a Hospital		
4	Do you have a written agreement with a physician who is certified by the American Board of Obstetrics and Gynecology? If no, please explain.				☐ Yes	☐ No
5	Do you employ, contract with or supervise any medical professionals? If **YES**, Provide the number of professionals below:				☐ Yes	☐ No

		Type	Employed	Contracted	Supervised
a	Midwife	Certified Nurse Midwife			
		Nurse Midwife			
		Midwife			
b	Nurses	Nurse Practitioner			
		Registered Nurse			
		Licensed Practical Nurse			
c	Other (provide details)				
d	Doula				

6	Legal/Professional/Administrative Actions against you: If you answer **YES** to any of these questions, please describe in the Additional Information section or on a separate sheet.			
	a	Have your hospital or birthing center privileges ever been suspended, restricted, denied, placed in probationary status, or revoked?	☐ Yes	☐ No
	b	Has your midwifery certification or membership in any society or association ever been refused, suspended, revoked or voluntarily surrendered?	☐ Yes	☐ No
	c	Has your license(s) to practice midwifery ever been limited, suspended, revoked, denied, voluntarily surrendered or investigated by any licensing board or regulatory agency?	☐ Yes	☐ No
	d	Has any fee or professional relations complaints been registered against you with your association(s), hospitals(s), birthing center or a state licensing authority?	☐ Yes	☐ No
	e	Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness?	☐ Yes	☐ No
	f	Have you ever been charged with, or convicted of a crime other than minor traffic violations?	☐ Yes	☐ No

IV. PROCEDURES AND PRACTICE DETAIL

1	Average weekly practice hours		
2	Average number of patients seen per week?		
3	Average number of patient contacts per week?		
4	How many patients are not related to pregnancy?		
5	Are patients screened prior to delivery and determined to be low risk of complications and able to undergo a routine delivery? (Patients including but not limited to those with diabetes, pre-eclampsia, maternal high blood pressure, placenta problems, prior c-section delivery, multiple births or previous birth complications are not considered to be low risk.)	☐ Yes	☐ No
6	Do you obtain a written informed consent agreement from all patients?	☐ Yes	☐ No
7	Do you practice with no deliveries? If yes, please skip questions 9 through 14.	☐ Yes	☐ No
8	What is the procedure if patients are determined to be other than low risk?		
	a Referred to OB or other physician for medical care and/or delivery?	☐ Yes	☐ No
	b Other (describe in Additional Information section)	☐ Yes	☐ No

9	What is the annual number of the following procedures?				
			Projected	First Past Year	Second Past Year
	a	Vaginal Deliveries			
	b	Caesarian Sections – scheduled			
	c	Caesarian Sections – emergency			
	d	Multiple Births			
	e	Patients transferred to a hospital after delivery			
	f	VBACs			

10	If involved with C-Section deliveries, describe the role that you perform:	
	☐	Observe
	☐	Assist
	☐	Second Assist

	☐ Other (describe):					
11	What percentage of your deliveries is done in each of the following locations?					
	Number	Projected	First Past Year	Second Past Year		
	Hospital					
	Birthing Center					
	Home					
	Other (describe):					
12	Do you induce labor? If **YES**, with:				☐ Yes ☐ No	
	Pitocin/Oxytocin?				☐ Yes ☐ No	
	Amniotomy?				☐ Yes ☐ No	
	Other (describe)				☐ Yes ☐ No	
13	Do you use epidurals? If **YES**, who administers?				☐ Yes ☐ No	
14	Is a physician in attendance at any deliveries? If **NO**, describe :				☐ Yes ☐ No	
15	What is the status of any physician during any of your shifts?					
	On-Call				☐ Yes ☐ No	
	On-Site				☐ Yes ☐ No	
16	Do you act as a clinical preceptor for midwifery students? If **YES**, Number of Students per year?				☐ Yes ☐ No	
	Do you obtain Proof of Insurance for the students?				☐ Yes ☐ No	

V. PRIOR POLICY and LOSS INFORMATION

1	Provide the following information pertaining to your Professional Liability coverage over the past seven (7) years.						
	Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium	Total # of Claims
					☐ CM ☐ Occ		
					☐ CM ☐ Occ		
					☐ CM ☐ Occ		
					☐ CM ☐ Occ		
2	Have you ever practiced without Professional Liability insurance? If **YES**, when? From: to:						☐ Yes ☐ No
3	Have you ever had any insurance company decline, cancel, rescind or non-renew any Professional Liability Insurance Policy? (Response not required in the State of Missouri) If **YES**, please provide details:						☐ Yes ☐ No
4	Are you aware of any of the following: If **YES** to any of the below, provide details in the Additional Information section or on a separate sheet.						
	a	Known losses or claims that have not been reported to a current or prior insurance carrier or any other source from which payment might be made?					☐Yes ☐No
	b	A specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim, that has not been reported to a current or prior insurance carrier?					☐Yes ☐No
	c	Any request for medical records by a patient or an attorney which might result in a claim?					☐Yes ☐No
	d	Information relating to service(s) on a Board which might result in a claim?					☐Yes ☐No
	e	Any current or 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 service(s) that may result in a claim, claim, threat of claim, letter of intent, adverse result notice or attorney contact?					☐Yes ☐No
	f	Any involvement, now or ever, in any Professional Liability claim or suit? If **YES**, a **Claim Information Supplemental Application** must be completed for each claim.					☐Yes ☐No

VI. COVERAGE REQUESTED

NOTE: The Company may not offer or quote requested coverage.

Effective Date: Retroactive Date:

Important: Declarations Page of your current policy must be attached if a retroactive date is requested.

Limits of Liability:	☐ $ 100,000 / $300,000	**Deductible:**	None ☐
	☐ $ 200,000 / $600,000		Other: $
	☐ $ 250,000 / $750,000		
	☐ $1,000,000 / $3,000,000		

VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.
By signing this Application, you represent and agree to each of the following five (5) items:

1	You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and	
2	This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply)	
	☐ Claim Information Supplemental Application	☐ Statement of No Known Claims Letter
	☐ Other:	
3	Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:	
	a	Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
	b	Representations you are making on behalf of all persons and entities proposed to be insured;
	c	A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4	This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.	
5	You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.	

FRAUD WARNING

Notice to Applicants of all states except New Jersey, New York, Pennsylvania, and Washington D.C.:

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material 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 and 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 York Applicants:

Any person who knowingly and with the 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each provision.

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 a 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.

Notice to Washington D.C. 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.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

The applicant must sign this Application within thirty (30) days prior to the policy inception date.

Signature of Applicant:	**Date:**
Print or Type Name and Title:	

ADDITIONAL INFORMATION

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

Section # and Question #	**Comments**

Signature:	Date: