

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

Hickory Pointe, Suite 125, 2250 Hickory Road, Plymouth Meeting, PA 19462
 (610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com – Website: <http://www.pajua.com>

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:			<input type="checkbox"/> CNM		
First Name	Middle Name	Last Name			
Coverage Requested:	<input type="checkbox"/> Occurrence	<input type="checkbox"/> 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: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other (Use an attachment to list and explain)					
Business Phone: () _____		Home Phone: () _____			
Business Fax: () _____		E-mail Address: _____			
Date of Birth: _____			Social Security No.: _____		
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?
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> 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%):

List locations and Hospitals at which you will practice during the policy period (even if outside Pennsylvania). 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 _____

If any of the above are not to be covered, please indicate (no coverage will be provided for locations outside of Pennsylvania): _____

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)

Medical 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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Alcohol /Drug Addiction	<input type="checkbox"/> Obesity
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer, please describe _____
<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Carrying Multiples	
<input type="checkbox"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deliver babies - Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Routine Gynecological Care
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deliver babies – Birth Centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pap Smears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deliver babies – Private Homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Exams
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Normal Obstetrical Deliveries Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Exams
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assist in Caesarian Sections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prenatal care through 1st trimester
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perform Epidurals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prenatal care through 2nd trimester
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perform Episiotomies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prenatal care through 3rd trimester
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Partum Care				

Details/descriptions/lists/type for above:

Part VIII – Practice Organization

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

- | | |
|---|--|
| <input type="checkbox"/> A private independent midwifery solo practice | <input type="checkbox"/> Owner of a freestanding Birth Center |
| <input type="checkbox"/> A private independent group midwifery practice | <input type="checkbox"/> Employee of a freestanding Birth Center |
| <input type="checkbox"/> Employee of OB/GYN Medical practice | <input type="checkbox"/> Employee of a Hospital |
| <input type="checkbox"/> Government employee | <input type="checkbox"/> Home Births |
| <input type="checkbox"/> Other, please describe _____ | |

1. Name of corporation, partnership or employer: _____
2. 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. 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: _____
2. 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: _____
3. 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 HISTORIES

Request must be in writing and signed by the insured health care provider.
Must include health care provider's name and PA license number.
Include address of where loss runs are to be sent.

Requests are to be sent to:

Natalie McLaughlin
Mcare Fund
1062 Lancaster Avenue, Suite 15F
Rosemont, PA 19010

Natalie's telephone number: (610) 801-2200 x 3016

Natalie's fax number: (610) 801-2211

Natalie's email address: nmclaughli@state.pa.us

There is no fee involved for requesting the loss runs.

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)

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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:
