

Applicant's Name:			
First Name	Middle Name	Last Name	
Coverage Requested:	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	Requested Effective Date:	
Coverage Period if less than 1 year:	From:	To:	
Requested retroactive date			
(Coverage cannot begin prior to application and premium receipt by the JUA)			

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

**Application for Certified Nurse Midwife's Professional Liability Insurance
Limits of Liability: \$500,000 Per Occurrence / \$1,500,000 Per Annual Aggregate**

Part I - General Information					
Home Address:					
Number and Street		City	State	Zip	
Principal Business Address:					
Number and Street		City	State	County	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:			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	
If "new" to JUA:					
EIN or SS No:					

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 Eff.	Exp.	Coverage (Occurrence or Claims-Made)	Retroactive Date/Comments
				Occ CM	
				Occ CM	
				Occ CM	
				Occ CM	
				Occ CM	

Have any claims been made or suits brought against you during the past 10 years as a result of professional services rendered? Yes No If yes, attach a description of all claims made or suits brought.

Attach a copy of your current Declarations and Policy History / Claim History Reports or Loss Runs From Each of the Above Carriers or Self-Insurers.

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.

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?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a complete description of the incidents including the date and status of the incident.	

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

Part IV – Locations:

List locations and Hospitals at which you will practice during the policy period. 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

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: _____

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?	
			Yes	No
			Yes	No
			Yes	No

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: _____
Are you an employee independent contractor
Name of insurance company and policy number: _____
- 3. With respect to the *above questions* have any aspects of your practice changed in the past **2 years**? Yes No
If yes, give details: _____

Part VIII – Practice Organization

Please check the box that describes your practice:

- Sole Proprietor/Unincorporated Sole Corporation
- Employee of individual/Group (not a shareholder) Partner or partnership
- Corporate shareholder Hospital employee
- Government employee Industrial employee
- Independent contractor

- 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)