Applicant's Name: Name of the Entity			
Coverage Requested:	☐ **Occurrence** ☐ **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 BIRTH CENTER PROFESSIONAL LIABILITY INSURANCE
Limits of Liability: $500,000 per Occurrence / $1,500,000 per Annual Aggregate

Part I - General Information

Principal Office Address: _____
Number and Street City State Zip

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

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

EIN: _____ **PA Medical License No.:** _____

IS ABOVE ADDRESS ONLY LOCATION? ☐ **YES** ☐ **NO**
IF NO, ATTACH A LIST ADDRESS OF OTHER LOCATIONS.

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 the entity 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 plus Mcare.
Each of the current or prior carriers should be contacted with a request they send these reports. They are required to provide these reports requested. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if there have been 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? ☐ Yes ☐ No If yes, attach a complete description of the incidents including the date and status of the incident.

Print or type name and title: _____
(Name) (Position)

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

Part IV* - LIST NAMES OF ALL OFFICERS, PARTNERS OR MEMBERS

Name	Specialty	PA J.U.A. Policy Number	Name of Company if **NOT** Insured by J.U.A.

LIST ANY NON-MEDICAL PROFESSIONALS WHO ARE PRINCIPALS OF THE ENTITY

_____

_____

_____

PART V

1. Does any principal of entity practice in any state other than PA? ☐ Yes ☐ No
2. If "Yes", indicate:
   a. Name of Principal _____
   b. Name of Other State _____
   c. Percent of Patient Care in Pennsylvania __%

PART VI – PLEASE ANSWER. (IF NONE – INDICATE WITH A ZERO)

COMPLETE BELOW IF ANY OF THE FOLLOWING ARE EMPLOYED:

☐ Employed Midwives Number Employed _____

☐ Assistants Number Employed _____

PLEASE ATTACH A LIST OF EMPLOYED (List Name & License #)

☐ Contracted Midwives Number Contracted _____

PLEASE ATTACH A LIST OF CONTRACTED (List Name & License #)

☐ Other medical personnel Number Employed _____

Description of other positions: _____

INCLUDE ALL FOR EACH CATEGORY ABOVE EVEN IF COVERAGE IS PROVIDED ELSEWHERE.

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 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.

Print or type name and title: _____
(Name) (Position)

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