



Salt Lake City Area Office
 8722 S. Harrison St. Sandy, UT 84070
 P.O. Box 4439 Sandy, UT 84091
 800-257-5590 • Fax 801-304-5515

Chicago Office
 303 W. Madison Street Suite 2075
 Chicago, IL 60606
 800-456-4576 • Fax 312-408-8081

BIRTHING CENTERS

General Information

Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: () _____ Fax: () _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Producer No.: _____ Producer's Name: _____

Producer's E-mail: _____

Detailed description of business activities (specifically, and by location): _____

Is this a new business? Yes No If no, how many years have you been in business? _____

Applicant is: Individual Corporation Partnership Joint Venture

Other (please describe): _____

Annual Payroll: \$ _____

Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? Yes No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: () _____

Fax: () _____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

| | Coverage: | Coverage: | Coverage: |
|-----------------|-----------|-----------|-----------|
| Company Name | | | |
| Expiration Date | | | |
| Annual Premium | \$ | \$ | \$ |

- Has the Applicant or any predecessor or related person or entity ever had a claim? Yes No
- Completed Claims and Loss History form attached (REQUIRED)? Yes No
- Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? Yes No

If the standard markets are declining placement, please explain why: _____

2. Desired Insurance

Limit of Liability - Professional Liability Coverage:

Per Act/Aggregate

- \$100,000 per accident / \$300,000 aggregate
- \$200,000 per accident / \$300,000 aggregate
- \$250,000 per accident / \$500,000 aggregate
- \$250,000 per accident / \$750,000 aggregate
- \$250,000 per accident / \$1,000,000 aggregate
- Other: _____

Self-Insured Retention (SIR): \$5,000 \$10,000 \$25,000

3. Business Activities

1. Person providing accounting and tax services:

- a. Name: _____
- b. Mailing Address: _____
- c. City: _____ State: _____ Zip: _____
- d. E-Mail: _____
- e. Business Telephone Number: () _____ Fax: () _____

2. Identify the state agency that licenses and regulates birth centers in your state: _____

3. Is your facility licensed by this state agency? Yes No

If no, please explain: _____

4. Identify the state agency(ies) that license(s) and regulate the midwives in your Birth Center: _____

5. Are all of your midwives licensed by this agency(ies)? Yes No

If no, please explain: _____

6. Is your facility accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO)? Yes No

7. Is your facility accredited by Commission for Accreditation of Birth Centers (CABC)? Yes No

8. Number of years that this facility has been operating: _____

9. Number of years with the present owner: _____

10. Number of years with the current management: _____

11. Please provide copies of all licenses held by your facility.

12. Has your license been suspended, revoked or placed on probation within the last 5 years: Yes No

13. Facility Activity for the past six years:

| YEAR | NUMBER OF BIRTHS AT BIRTH CENTER | PLANNED HOSPITAL BIRTHS | HOME BIRTHS | IP TRANSFERS |
|------|----------------------------------|-------------------------|-------------|--------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| YEAR | NEWBORN DEATHS WITHIN 7 DAYS OF LIFE | STILLBIRTHS | MATERNAL DEATHS |
|------|--------------------------------------|-------------|-----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

14. Number of Birthing Rooms: _____ Number of Birthing Tubs: _____

Number of Exam Rooms: _____

15. What is the minimum length of stay? _____ hours

What is the maximum length of stay? _____ hours

16. What is the minimum gestation for a baby delivered at the Birth Center? _____

17. Indicate the name of the Administrator and provide a brief summary of administrative experience: _____

18. Do you employ a medical director? Yes No

If yes, describe the director's medical qualifications: _____

19. Do you wish the medical director to be insured through the Birth Center? Yes No

If yes, please complete and submit a Medical Director Application (available online at www.primeis.com).

20. Does the Birth Center utilize students in any capacity? Yes No

If yes, explain fully: _____

Do these students carry liability coverage? Yes No

21. Explain the medical director's duties and responsibilities. Attach an employment agreement if one exists.

22. Employee Profile (please indicate the number of each kind of employee):

| EMPLOYEE CLASSIFICATION | NUMBER OF EMPLOYEES |
|----------------------------|---------------------|
| Birth Assistants | |
| Doulas | |
| LPNs | |
| Midwives | |
| Non Medical/Administrative | |
| Nurse's Aides | |
| Other | |
| Physicians | |
| RNs | |
| Students | |
| Total | |

23. Give a summary of the procedures you use when hiring a medical professional at your facility. _____

24. If an individual has had a previous medical professional claim, how would it affect your hiring of that person?

25. Do you have a transfer agreement with a physician and/or a hospital? Yes No
If yes, please identify: _____

26. Smoke Detectors are located: None Entire Facility Common Areas Hallways Patient or Resident Rooms Other: _____

Areas protected by approved automatic sprinkler system: None Entire Facility Common Areas Hallways Patient or Resident Rooms Other: _____

27. When was the last time that this building's electric, heating, and plumbing systems were inspected or updated?

| | ELECTRIC | HEATING | PLUMBING |
|----------------------|----------|---------|----------|
| Qualified Inspection | | | |
| Replaced or Updated | | | |

28. When was this building last inspected by the:
Local fire authorities: _____ State Department of Health: _____
(If the inspection was completed in the last three years, please include a copy)

29. Are there at least two exits on every floor? Yes No

30. Are handrails provided in hallways and bathrooms? Yes No

31. Are bathtubs and showers equipped with non-slip surfaces? Yes No

32. Are all skilled and intermediate beds equipped with side rails? Yes No
33. Have you had any professional or general liability claims made in the last five years? Yes No

NOTE: If you would like to insure Midwives, please complete the Midwife Supplemental Application in conjunction with this Application.

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____

Dated: _____

Applicant:

Agent/Broker:

Signature

Signature

Print Name

Print Name

