



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

**MIDWIFE OR MIDWIFE
 STUDENT**

General Information

Proposed Effective Date: _____

Applicant is (check all that apply): CNM CPM LM Other: _____

Applicant is licensed in which states? _____

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: an Individual a Corporation a Partnership a 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	\$	\$	\$
Coverage Limits			

If you carry malpractice insurance, where does it cover your work?

- Home Births Hospital Clinics

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:

- \$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 / \$1,000,000 aggregate
- Other: _____

Self-Insured Retention (SIR): \$1,000 (Minimum) \$1,500 \$2,500 \$5,000 \$10,000

3. Business Activities

1. Annual Gross Income: \$ _____

2. Please show the categorization of Income for the previous 12 months:

	Income
Births	\$
Gynecology	\$
Coaching / Doulas	\$
Childbirth Education	\$
Other	\$
Total	\$

3. Person providing accounting and tax services:

a. Name: _____

b. Address: _____

4. Are you seeking:

a. Insurance to cover work done exclusively by you? Yes No

b. Insurance to cover work done by others under your direction? Yes No

c. Insurance to cover the actions of individuals on your payroll?

Yes No

5. Employee breakdown—please enter the number of:

	Full-Time	Part-Time
Operational Staff		
Non-Operational employees (drivers, collectors, supervisors, etc.)		

6. Describe in detail the regular operations and services you provide: _____

7. Provide names of any partners or principal owners involved in the business:

TITLE	NAME	YEARS WITH THE BUSINESS	YEARS OF EXPERIENCE

8. If licensed, do you have admitting privileges of your own at any hospital(s)? Yes No

9. If yes, which hospital(s)? _____

10. Have you ever applied for admitting privileges and been turned down? Yes No

11. Please attach a copy of risk criteria.

12. If you attend home births, please list the following:

a. Supplies and equipment you take to home births: _____

b. Prescription drugs you take to home births: _____

13. Who assists you, and what are their qualifications? _____

14. Do you have transfer agreements with any hospitals? Yes No

If yes, please identify: _____

15. Number of births during the past 12 months:

BIRTHING CENTERS	HOMES	HOSPITALS

16. Number of births estimated for the next 12 months:

BIRTHING CENTERS	HOMES	HOSPITALS

17. Number of births during the past six years:

YEAR	BIRTHING CENTERS	HOMES	HOSPITALS
20__			
20__			
20__			
20__			
20__			
20__			

- 18. Do you work under physician supervision? Yes No
- 19. Do you have a physician write orders? Yes No
- 20. Do you have prescriptive privileges? Yes No
- 21. Do you supervise students? Yes No

4. Education

- 1. What is the name of the midwife school you attended? _____
- 2. What is the approximate time period you attended this school? From: _____ To: _____
- 3. How many babies did you assist to deliver as a student? _____
- 4. How many births did observe while in school? _____
- 5. Please list the names of your instructors during your apprenticeship: _____

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