Salt Lake City Area Office
8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
800-257-5590 • Fax 877-452-6910

BIRTHING CENTERS

1. 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's Name: ______

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

______

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

Applicant is: o Individual o Corporation o Partnership o Joint Venture o Other: ______

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? o Yes o No

If yes, please tell us:

Employee Name: ______

E-Mail: ______ Business Telephone No.: ______

Fax: ______ Years with Company: ______

Employee's Responsibilities: ______

2. 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? o Yes o No

Completed Claims and Loss History form attached (REQUIRED)? o Yes o 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: ____________________

3. 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

4. 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. Annual income for the past 12 months, and estimated for the next 12 months:

	BIRTHING CENTERS	HOMES	HOSPITALS
Past 12 mo.	$	$	$
Next 12 mo.	$	$	$

14. Number of births during the past 12 months:

BIRTHING CENTERS	HOMES	HOSPITALS

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

BIRTHING CENTERS	HOMES	HOSPITALS

16. 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

17. Number of Birthing Rooms: ________________ Number of Birthing Tubs: ______________

    Number of Exam Rooms: _______________

18. What is the minimum length of stay? ____________ hours

    What is the maximum length of stay? ____________ hours

19. What is the minimum gestation for a baby delivered at the Birth Center? ______________________________

20. Indicate the name of the Administrator and provide a brief summary of administrative experience: __________

    ____

21. Do you employ a medical director? ☐ Yes ☐ No

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

    ____

22. 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).

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

    If yes, explain fully: ____

    Do these students carry liability coverage? ☐ Yes ☐ No

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

____

____

25. 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	

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

____

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

____

____

28. Do you have a transfer agreement with a physician and/or a hospital? ☐ Yes ☐ No

If yes, please identify: ____

29. 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:______________________

30. 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			

31. 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)

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

33. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

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

35. Are all skilled and intermediate beds equipped with side rails? ☐ Yes ☐ No

36. 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

UNDERWRITERS DIRECT ACCESS™

Salt Lake City Area Office
8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
800-257-5590 • Fax 877-452-6910

Chicago Office
303 W. Madison Street Suite 2075
Chicago, IL 60606
800-456-4576 • Fax 888-408-8081

STAFF RECAP

General Information Proposed Effective Date: ____________________

Applicant's Name: ____

Applicant's Mailing Address: ____

City: ______________________ State: ________ Zip: ________________

E-Mail: ______________________________ County: ________________

Business Telephone Number: ( )________________ Fax: ( )________________

NAME	AGE	YEARS OF EXPERIENCE	TYPE OF TRAINING	CERTIFICATIONS HELD	OUTSTANDING COMPLAINTS