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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 Address 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

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

____

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