



Welcome to our site. Southern Cross Insurance Solutions is an independent insurance agency with access to multiple carriers across state lines. We strive to make the best match between our clients and carriers to provide for your needs. One of the possible placements for our Midwifery Program Clients would be Medical Protective (MedPro Group) so we ask that you complete and return the attached application to Ann Geisler or Melanie Hart. We will review the application and submit it for a quote for MedPro and/or another carrier.

**Ann Geisler:** [ageisler@southerncrossins.com](mailto:ageisler@southerncrossins.com) **New Business**

**Melanie Hart:** [mhart@southerncrossins.com](mailto:mhart@southerncrossins.com) **Renewal Business**

**Fax: 407-985-3556 New and Renewal Business**

Sincerely,

*Ann A. Geisler, CPCU, AU, AAI  
President*



**Southern Cross Insurance Solutions home of The Midwife Plan**

P.O. Box 568428, Orlando, FL 32856

Phone: 407-985-3542

Toll Free: 888-985-3542

Fax: 407-985-3556

Emily Lacy direct (321)806-0018, [emily@southerncrossins.com](mailto:emily@southerncrossins.com)

Ann Geisler ext. #1 [ageisler@southerncrossins.com](mailto:ageisler@southerncrossins.com)

**Ann's Cell Phone: 407-491-4007**

Melanie Hart ext. #2 [mhart@southerncrossins.com](mailto:mhart@southerncrossins.com)

Marilyn Praytor ext. #3 [mpraytor@southerncrossins.com](mailto:mpraytor@southerncrossins.com)

We will continue to partner with Hugh Cotton Insurance on some of your policies so we can gain access to more markets for you!

[www.southerncrossins.com](http://www.southerncrossins.com) [www.themidwifeplan.com](http://www.themidwifeplan.com)

*As an independent broker, we have many markets to work with. So don't forget we can assist you with your business insurance needs including General Liability, Property, Workers' Compensation, Business Auto, Bonds, Etc.*

**National Fire & Marine Insurance Company**  
 Omaha, Nebraska  
**MULTI-SPECIALTY HEALTHCARE PROFESSIONAL  
 MIDWIFE AND BIRTHING CENTER**  
**CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION**

**APPLICATION INSTRUCTIONS**

1. Individual applicants should begin this application in Section I., General Information, Individual Applicant.
2. Entity/Group applicants should begin this application in Section I., General Information, Entity/Group Applicant.
3. If additional space is needed, use the Section VIII., Supplemental Information with reference to the relevant question.
4. Print legibly. Answer all questions; if a question is not applicable, state "N/A".

**I. GENERAL INFORMATION**

**INDIVIDUAL APPLICANT:**

**A. Please check all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Sole Proprietor/Solo Incorporated                    | <input type="checkbox"/> Employed or Contracted with a Hospital                      |
| <input type="checkbox"/> Owner of a Birthing Center                           | <input type="checkbox"/> Employed or Contracted with an OBGYN                        |
| <input type="checkbox"/> Employed or Contracted with a Midwife Group Practice | <input type="checkbox"/> Joining a National Fire & Marine Midwife Group Policy _____ |
| <input type="checkbox"/> Other, please explain: _____                         |  |

**B.** \_\_\_\_\_

<b>First Name</b> _____	<b>M.I.</b> _____	<b>Last Name</b> _____	<b>Designation</b> _____
<b>Training/Program/School Name</b> _____			<b>Graduation Date</b> _____
<b>Date of Birth</b> ____/____/____	<b>License/Certification #</b> _____	<b>Hours Practicing Per Week</b> _____	<b>Retroactive Date</b> _____
<b>Phone</b> ____-____-____	<b>Email</b> _____		

**C. List professional associations or societies of which you are a member:** \_\_\_\_\_

**D. Do you need coverage for an entity that you own?**  YES  NO  
 If yes, proceed to the Entity/Group Applicant Section below.  
 If no, proceed to Section II., Practice Information.

**ENTITY/GROUP APPLICANT:**

**A. Please check all that apply:**

- |  |  |
|--|--|
| <input type="checkbox"/> Professional Corporation: Sole Shareholder        | <input type="checkbox"/> Professional Corporation: Multiple Shareholders |
| <input type="checkbox"/> Partnership or Professional Association           | <input type="checkbox"/> Other, please explain: _____                    |
| <input type="checkbox"/> Limited Liability Company (LLC)/Partnership (LLP) |  |

**B.** \_\_\_\_\_  
**Entity Name** (As stated in the legal documents filed with the state.)

**If the entity does business under any other name, list additional entity/clinic name(s), Doing Business As ("DBA"), fictitious name, etc.** \_\_\_\_\_

<b>State of Incorporation</b> _____	<b>Tax I.D. Number</b> _____	<b>Date Entity Formed</b> ____/____/____	<b>Entity Retroactive Date</b> ____/____/____
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**C. FOR GROUP APPLICANTS ONLY:**

<b>Primary Contact Name</b> _____	<b>Title</b> _____
<b>Phone</b> ____-____-____	<b>Email</b> _____



## II. PRACTICE INFORMATION CONTINUED

E. Indicate the total number for each of the following items for you, your entity, any applicant requesting coverage, or any of your employees or independent contractors:

Total	Last 12 Months	Next 12 Months
Birthing Center Deliveries		
Home Deliveries		
Hospital Deliveries		
Clinic Visits (excluding pregnancy visits)		
Family Planning/Well-Woman Care Visits		
Of the total deliveries noted above, indicate how many are:	Last 12 Months	Next 12 Months
VBACs performed in a Birthing Center		
VBACs performed in a Home*		
VBACs performed in a Hospital		

\*Note: The National Fire & Marine policy will not provide coverage for VBACs performed in a home or in a non-clinical setting.

F. Indicate the total number of hours working per week for all employed and contracted individuals that will provide professional services on behalf of you or the Entity/Group:

Healthcare Provider	Total Hours per Week
Birth Assistants	
Doulas	
Student Midwives	
Massage Therapists	
Acupuncturists	

## III. PROFESSIONAL INFORMATION

A. Have you, your entity, any applicant requesting coverage, or any of your employees or independent contractors ever:

1. Been charged with, convicted of, or indicted for any act committed in violation of any law or ordinance, other than traffic offenses?  YES  NO
2. Had hospital privileges, DEA license, healthcare license or reimbursement privileges denied, refused, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?  YES  NO
3. Been accused of sexual misconduct of any kind?  YES  NO
4. Been aware of having a health condition that could impair the ability to practice their profession? (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics, or other controlled substances, etc.)  YES  NO
5. Cancelled, declined, non-renewed or had a prior insurance policy rescinded for any type of professional insurance; e.g., malpractice, general liability, cyber/privacy liability, and/or employment liability?  YES  NO

If yes, to any questions in this section, provide the information below. If additional space is needed, use Section VIII., Supplemental Information.

Explanation: \_\_\_\_\_

Applicant Name(s): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_





**VII. NOTICES AND AGREEMENTS**

**MANDATORY: ALL APPLICANTS must read the following:**

**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, which may include voiding of the policy if allowed by state law.**

By my signature, I hereby represent that all applicants have granted me full authority to execute this application on his, her or the entity's behalf and I am authorized to represent and sign on behalf of anyone from my practice. I also represent that I have reviewed the responses contained in this application with the applicants, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicants and that they understand and agree that such representations are binding upon him, her or the entity, even though I am executing this application on the applicants' behalf.

I further acknowledge that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "**Attachments**") for the purposes of my, or any applicants' initial or renewal application, are true and that I, nor any applicant, have not knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in professional specialty, affiliation or working arrangement with any other healthcare professional, facility, firm or professional association.

I understand that any material misrepresentation or omission made by me or any other applicant on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not, nor is any other applicant relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.

I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I or any applicant understands that if payment of premium or first installment is by check, electronic transfer or money order, it shall not be considered "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I, OR ANY APPLICANT, FAIL TO COMPLY WITH THESE TERMS WE **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

I, or any other applicant, understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me or any applicant, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

By signing this application on behalf of a group, or an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I warrant that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

**Application must be signed by the Individual Applicant, a President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or Office Administrator or equivalent Authorized Representative on behalf of all members of the Entity/Group.**

\_\_\_\_\_  
Applicant or Authorized Representative Signature/Title

\_\_\_\_\_  
Printed Name

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Agent/Producer Name

\_\_\_\_\_  
Agent License Number

**VIII. SUPPLEMENTAL INFORMATION**

Blank lines for supplemental information.

**National Fire & Marine Insurance Company**  
**HEALTHCARE PROFESSIONAL INSURANCE**  
**Loss Information Supplement - Midwife**  
Please complete for each claim, lawsuit or incident.

**Group Name:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Applicant/Insured Name:** \_\_\_\_\_

**A. Is the matter related to a:** (Check only one)

\_\_\_\_ Current or prior claim or lawsuit

\_\_\_\_ Complication, incident or adverse outcome that may lead to a claim or lawsuit

**B. What coverage type applies to the matter? (Professional Liability, General Liability, EPLI, Cyber, etc.):** \_\_\_\_\_

**C. Patient/Claimant Name:** \_\_\_\_\_  
First Name Last Name

**D. Date of treatment/incident:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**E. Date you received notice of the matter:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**F. Date reported to insurance company:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**G. Insurance Company Name:** \_\_\_\_\_

**H. Name of all other defendants, if any, involved:** \_\_\_\_\_

**I. Current status:** \_\_\_\_ Open \_\_\_\_ Closed

**1. If open, indicate dollar value established by insurance company:** \$ \_\_\_\_\_

**2. If closed, date of closing:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**Total settlement or award made:** \$ \_\_\_\_\_

**Settlement or award made on your behalf:** \$ \_\_\_\_\_

**J. What was the alleged negligence?** \_\_\_\_\_

**K. What was the alleged injury?** \_\_\_\_\_

**L. Provide complete details of your involvement in the matter:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_