



Welcome! 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 this application to Ann Geisler or Melanie Hart. We will review the application and submit it for a quote from MedPro and/or another carrier.

Ann Geisler: ageisler@southerncrossins.com **New Business**

Melanie Hart: mhart@southerncrossins.com **Renewal Business**

Fax: 407-985-3556 New and Renewal Business

Sincerely,

Ann A. Geisler, CPCU, AU, AAI
President

t 407-985-3542 or 888-985-3542 | ext. 1
c 407-491-4007
e ageisler@southerncrossins.com

Southern Cross Insurance Solutions
P.O. Box 568428, Orlando, FL 32856 | Fax: 407-985-3556
Home of The Midwife Plan | www.themidwifeplan.com

Need to reach another expert on my team?

Melanie Hart

t 407-985-3542 or 888-985-3542 | ext. 2
e mhart@southerncrossins.com

We will continue to partner with Hugh Cotton Insurance on some policies so we can gain access to more markets for you! Also, as an independent broker, we work with many markets, and so please don't forget we can assist you with your business insurance needs including: General Liability, Property, Workers' Compensation, Business Auto, Bonds, and more!

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.

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

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. _____

State of Incorporation _____	Tax I.D. Number _____	Date Entity Formed _____	Entity Retroactive Date _____
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C. FOR GROUP APPLICANTS ONLY:

Primary Contact Name _____	Title _____
Phone _____	Email _____

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: ____ / ____

V. LOSS INFORMATION

For the following section, include information for all types of professional liability insurance; e.g., malpractice; general liability; cyber/privacy liability; and/or employment practices liability. A **Loss Information Supplement** must be completed for each.

- A. Have you, your entity, any applicant requesting coverage, or any of your employees or independent contractors ever been:**
1. **Involved in a claim e.g., demand for money?** Yes No
If yes, how many? _____
 2. **Involved in a lawsuit?** Yes No
If yes, how many? _____
 3. **Aware of any complication, event, incident or adverse outcome that might reasonably result in a claim or lawsuit or had a request for a patient's medical records from an attorney?** Yes No
If yes, how many? _____
 4. **Involved in the treatment of a patient that resulted in postpartum hemorrhage, shoulder dystocia, cooling after birth, resuscitation after birth or maternal or fetal death?** Yes No
If yes, how many? _____

VI. COVERAGE INFORMATION

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to Claims-Made coverage or the additional expense associated with an "extension contract(s)" or "tail coverage".

- A. Coverage Effective Date:** _____ / _____ / _____ 12:01 AM Annual policy terms will begin and end on the same month/day.
(MM/DD/YYYY)
- B. Limits of Liability:** Select only one. Not all Limits of Liability are available in all states.
- | | |
|---|---|
| <input type="checkbox"/> \$100,000 per claim / \$300,000 annual aggregate | <input type="checkbox"/> \$500,000 per claim / \$1,500,000 annual aggregate (only available in CO, CT and IN) |
| <input type="checkbox"/> \$200,000 per claim / \$600,000 annual aggregate | <input type="checkbox"/> \$1,000,000 per claim / \$3,000,000 annual aggregate |
| <input type="checkbox"/> \$250,000 per claim / \$750,000 annual aggregate | <input type="checkbox"/> Other: \$ _____ per claim / \$ _____ annual aggregate |
| <input type="checkbox"/> \$500,000 per claim / \$1,000,000 annual aggregate | |
- C. Prior Carrier Information:** Provide information for all professional liability insurance companies that have provided coverage for the applicant for the last 3 years. List "N/A" if there has not been coverage in the last 3 years.

Insurance Carrier	Limits of Liability	Deductible/ Retention	Policy Period (MM/DD/YY - MM/DD/YY)	Retroactive Date (MM/DD/YY)	Premium

- D. If the most recent prior coverage was issued on a Claims-Made basis and a different retroactive date, from what is on the most recent declarations page, is being requested, please select one of the following:**
- Not Applicable** — the retroactive date being requested is the same retroactive date that I have with my current carrier.
 - An extension contract endorsement (tail coverage) **has been or will be purchased.**
 - An extension contract endorsement (tail coverage) **has not and will not be purchased.** I will not purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy, for which I am applying from The National Fire & Marine Insurance Company, will not provide Prior Acts coverage.
- E. Would you like to purchase General Liability coverage (Bodily Injury/Property Damage) for an additional charge?** Yes No
If yes, are you required by contract to name an Additional Insured on your General Liability Policy? Yes No
1. **If yes,** provide the information requested below. If you have more than one Additional Insured that is required by contract to be named on your policy, provide their name, mailing address and nature of professional relationship to you in Section VIII., Supplemental Information.
Additional Insured Name: _____
Practice Address: _____
Street Address _____ Suite _____ City _____ State _____ Zip Code _____
Nature of Professional Relationship to you:
 Lessor of Equipment – Rent or Lease Equipment – Description of Equipment: _____
 Lessor of Premises – Own, Rent or Lease Location
 Other – Explain: _____

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:

