



Medical Professional Liability Insurance Application Certified Nurse Midwives

I warrant that all information in this application is true and complete and understand that this application form shall be the basis for endorsing my employer's/supervisor's Medical Professional Liability contract with American Physicians Insurance Company.

INSTRUCTIONS:

1. Answer all questions. If a question is not applicable, state NOT APPLICABLE.
2. If space is insufficient to answer any questions fully, attach separate sheet.
3. Application must be signed and dated.
4. If the answer to any question is none, state NONE.
5. Please submit a written protocol and (if seeking vicarious coverage) proof of individual coverage. Application will not be considered complete without these items.

PLEASE TYPE OR PRINT IN BLACK INK AND ANSWER ALL QUESTIONS IN DETAIL. COVERAGE WILL NOT BE CONSIDERED UNTIL APPLICATION IS COMPLETED AND SIGNED.

PERSONAL INFORMATION

Full Name _____ Sex: Male Female

Social Security # _____ Date of Birth ____/____/____

Place of Birth _____ Are you a U.S. Citizen? Yes No

Home Address _____ Street & Number _____ City _____ County _____ State _____ Zip Code _____

Home Phone _____ E-mail _____

CONTACT INFORMATION

Business Address _____ Street & Number _____ City _____ County _____ State _____ Zip Code _____

Business Phone _____ Business Fax _____

Business Website _____

Office Contact Name _____ Office Contact E-mail Address _____

Office Contact Title _____

Office Contact Phone _____ Office Contact Fax _____

Administrator Name _____ Administrator E-mail address _____

Administrator Phone _____ Administrator Fax _____

CLAIMS HISTORY

PLEASE NOTE THAT A COMPLETE CLAIM/ SUIT ADDENDUM IN THE APPLICANT'S OWN WORDS FOR EACH INCIDENT NOTED BELOW MUST BE ATTACHED FOR THE APPLICATION TO BE PROCESSED

LIST ALL CLAIM(S) INFORMATION FROM JANUARY 1, 2003 TO THE PRESENT

- All claims listed on your application must have been reported to your prior insurer(s).
- All claims not listed on your application must have been reported to your prior insurer(s).
- A claim, potential claim, incident, or lawsuit reported to a previous insurer is not covered by American Physicians Insurance Company . Furthermore, under no circumstances or event will any coverage apply to any claim, potential claim, incident, or lawsuit which is known or which may arise out of any incident which is known by any named insured, physician extender, or ancillary personnel as of the effective date of this policy. It is your responsibility to report all claims, potential claims, incidents or lawsuits, which are known or which may arise out of an incident which is known, to your previous insurer(s).

1. Are you now or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising from the rendering of, or failure to render professional services?

Yes No

If yes, how many? _____ A number must be specified along with the corresponding narrative(s)

2. If you are a member of a Partnership, Professional Corporation or Professional Association, do you have knowledge of any claims or potential claims arising from the rendering of, or failure to render professional services involving former or present partners, members of the corporation, or any former or present employee of the Corporation, Partnership, or Professional Association?

Yes No

If yes, how many? _____ Have these been reported to your previous insurer(s)? Yes No

Claims listed as part of this application are not considered claims reported to us.

CURRENT PROFESSIONAL LIABILITY INFORMATION

Please complete the following indicating your Professional Liability carrier(s) since your requested retroactive date. PLEASE ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR CURRENT POLICY OR A CERTIFICATE OF INSURANCE ISSUED FROM YOUR CURRENT CARRIER REFERENCING YOUR CURRENT POLICY.

Professional Liability Carrier	Limits of Liability	Dates Insured	Type
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)

TYPE OF PRACTICE

- | | |
|--|---|
| <p>I am an</p> <p><input type="checkbox"/> Employee</p> <p><input type="checkbox"/> Independent Contractor</p> <p><input type="checkbox"/> Self-Employed</p> <p><input type="checkbox"/> Other _____</p> | <p>Of a</p> <p><input type="checkbox"/> Hospital</p> <p><input type="checkbox"/> Medical Practitioner/Group</p> <p><input type="checkbox"/> Hospital Birth Center License _____</p> <p><input type="checkbox"/> Other _____</p> |
| | <p><input type="checkbox"/> PA</p> <p><input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Corporation</p> |

Name of Practice	Address	City	State	Zip Code
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Date(s) you begin working for the practice listed above? _____

1. Do you have on-site supervision for all procedures? Yes No
 By whom? _____

2. Please indicate the percentage of time spent in the following work locations:
 Hospital _____% Surgery Center _____% Birth Center _____% Home _____% Other (please describe) _____

3. Do you perform unassisted surgical procedures? Yes No
 If yes, please explain _____

4. Do you carry out treatment plans without the direct supervision of your physician employer? Yes No
 If yes, please explain _____

5. Do you see patients or make hospital rounds without the direct supervision of physician employer? Yes No
 If yes, please explain _____

6. Do you perform Norplant procedures? Yes No
 Insertion Removal
 Please describe your Norplant experience and/or training _____

7. Do you take calls for Physicians other than your employer? Yes No
 If yes, please explain _____

8. Do you work in a location other than where your employer/supervisor provides services? Yes No
 If yes, please explain _____

9. Do you have prescriptive authority for Controlled Substances? Yes No
 If yes, DEA# _____ Expiration date _____
 Delegating Physician _____

10. Do you perform any invasive procedures without the direct supervision of your physician employer?

If yes, please explain _____

11. How many deliveries did you perform last year? _____

12. Do you participate in the performance of Cesarean Sections as part of your practice? Yes No

If yes, specify in what capacity: _____

13. Does your employment/practice require that you ever be in an operating room? Yes No

If yes, do you: Observe Assist Second Assist Other

If other, please describe: _____

14. Is the informed consent process documented in all patients' medical records? Yes No

15. Is baseline fetal monitoring used when the patient presents for evaluation of active labor? Yes No

16. Do you maintain a current CPR status relevant to adult resuscitation? Yes No

a. Are you ACLS certified? Yes No

b. Do you maintain a current CPR status relevant to neonatal resuscitation? Yes No

If, no please explain _____

c. Are you PALS certified? Yes No

GENERAL INFORMATION

1. Have any of the following, now or ever, been under review, under investigation, revoked, denied, suspended, voluntarily surrendered, or in any way limited?
- Your permit to prescribe or dispense drugs Yes No
 - Your nursing certification and/or license Yes No
 - Your hospital privileges Yes No
 - Your Medicare/Medicaid accreditation, certification, or Medicare/Medicaid license Yes No
2. Have you ever been or are you now under review by any entity, organization or peer review board? Yes No
3. Have you even been under review or investigated by any State Medical Board? Yes No
4. Have you ever been or are you now being investigated, charged with, or convicted of a felony or state jail felony? Yes No
5. Have you ever been, or are you now, being treated for:
- Chronic illness or physical disability which may limit your abilities to practice Yes No
 - Alcoholism or narcotic addiction Yes No
 - Mental illness Yes No

6. Have you ever been advised that your medical professional liability insurance would or might be declined, non-renewed, or accepted on special terms?
 Yes No

7. Have you ever been or are you now an employee of or do any contract work for any federal, state, local or government agency? Yes No

If "yes", please give details, including whether professional liability insurance is provided for you.

8. Are you currently an employee of or do contract work for any other entities, including other physicians, emergency room (s), or minor emergency medical organizations for which you are paid? Yes No

If yes, please list _____

Do you require coverage for this practice? Yes No

9. If you answered "yes" to any question in the General Information section, please explain in detail below or attach an explanation to this application. _____

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with the company, American Physicians Insurance Company. All statements are my own representations and are true, to the best of my knowledge. I have not knowingly withheld any information that is calculated to influence the judgment of the Company in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance on the truth of my representations. I understand that no insurance will be afforded unless and until this application is approved by the company and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by the company. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, and individuals. I expressly release and discharge the aforesaid entities, their agents, employees and/ or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as the evaluation of information so received from whatever source.

I understand that, if I am insured by the company, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with the company and any party furnishing information pursuant to this authorization is entitled to rely on the representation of the company that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to the company.

Signature

Print Full Name

Date

PLEASE COMPLETE ENTIRE APPLICATION, AND SUBMIT WITH COPY OF PROTOCOLS AND COPY OF INDIVIDUAL CERTIFICATE OF INSURANCE.

INCOMPLETE APPLICATIONS WILL BE RETURNED

NOTE: Signature of this form does not bind the Applicant or the Company and no insurance coverage will be considered to be in effect until the applicant has received a confirmation in writing, duly executed by the company.



Claim/Suit Information Addendum

COMPLETE ONE CLAIM/SUIT INFORMATION ADDENDUM IN THE APPLICANT'S OWN WORDS FOR EACH INCIDENT, CLAIM OR SUIT.
PLEASE PRINT ALL INFORMATION.

Doctor's Name _____

1. Name, age, and sex of patient/claimant _____

2. Date(s) of treatment and/or surgery which led to the allegations against you (month/year) _____

3. Nature of the allegations in the claim or suit, or description of medical incident _____

4. Specify incident or claim report date(s) _____

5. Specify if a suit was ever filed: Yes No If yes, provide (month/year) _____

6. Name of the other doctor(s) and hospital(s), if any, involved in claim or suit _____

7. Disposition or current status of incident, claim or suit

- Incident only.
- OPEN CLAIM-Indicate case value established by insurance company, if known \$ _____
- CLOSED CLAIM-Was payment made? Yes No If yes, when ____/____/____
- If no, was claim or suit withdrawn? Yes No
- If payment was made, indicate amount of settlement \$ _____ award \$ _____
- Amount paid on your behalf: _____

8. Name of insurance company defending you _____
Policy Number _____

9. Narrative description of the medical facts (must include, but is not limited to, the type of treatment and/or surgery; and your involvement, i.e., consultant, assistant in surgery, E.R. physician, primary surgeon, resident, etc.).

