***PLEASE RETURN TO FAX: 407-985-3556 or ageisler@southerncrossins.com

Southern Cross Insurance Solutions, LLC
Orlando, FL 32856
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:

- ☐ Sole Proprietor/Solo Incorporated
- ☐ Owner of a Birthing Center
- ☐ Employed or Contracted with a Midwife Group Practice
- ☐ Employed or Contracted with a Hospital
- ☐ Employed or Contracted with an OBGYN
- ☐ Joining Southern Cross Insurance Solutions Group Policy _____
- ☐ Other, please explain: _____

B.

_____ _____ _____ _____
First Name **M.I.** **Last Name** **Designation**

_____ _____/_____
Training/Program/School Name **Graduation Date** (MM/YYYY)

_____/_____/_____ _____ _____ _____/_____/_____
Date of Birth (MM/DD/YYYY) **License/Certification #** **Hours Practicing Per Week** **Retroactive Date** (MM/DD/YYYY)

_____-_____-_____ _____
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.
If no, proceed to Section II., Practice Information.

ENTITY/GROUP APPLICANT:

A. Please check all that apply:

- ☐ Professional Corporation: Sole Shareholder
- ☐ Partnership or Professional Association
- ☐ Limited Liability Company (LLC)/Partnership (LLP)
- ☐ Professional Corporation: Multiple Shareholders
- ☐ Other, please explain: _____

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** (MM/YYYY) **Entity Retroactive Date** (MM/DD/YYYY)

C. FOR GROUP APPLICANTS ONLY:

_____ _____
Primary Contact Name **Title**

_____-_____-_____ _____
Phone **Email**

II. PRACTICE INFORMATION

A. Practice Location(s): (Please list primary location first. Combined percentage for all locations must total 100% and cannot be of equal values.)

1. Type of Facility: □ Office □ Hospital □ Birthing Center (Accredited) □ Birthing Center (Not Accredited) □ Other:_____

____% of Practice _____ _____
Name of Primary Practice Location **County**

_____ _____ _____ _____ _____
Street Address **Suite** **City** **State** **Zip Code**

2. Type of Facility: □ Office □ Hospital □ Birthing Center (Accredited) □ Birthing Center (Not Accredited) □ Other: _____

____% of Practice _____ _____
Name of Practice Location **County**

_____ _____ _____ _____ _____
Street Address **Suite** **City** **State** **Zip Code**

3. Type of Facility: □ Office □ Hospital □ Birthing Center (Accredited) □ Birthing Center (Not Accredited) □ Other: _____

____% of Practice _____ _____
Name of Practice Location **County**

_____ _____ _____ _____ _____
Street Address **Suite** **City** **State** **Zip Code**

B. List all states in which services are provided in a patient's home: _____

C. Billing and Correspondence Address:
□ Location # (from Question A above): _____ □ Other (Please enter below):

_____ _____ _____ _____ _____
Street Address **Suite** **City** **State** **Zip Code**

D. Do you, your entity, or any applicant requesting coverage, or any of your employees or independent contractors:

1. Have written collaborative practice agreements in place where applicable under state law? □ **YES** □ **NO**

If no, explain:_____

2. Have a transfer agreement with any hospital? □ **YES** □ **NO**

If no, explain:_____

3. Provide treatment at a correctional facility? □ **YES** □ **NO**

If yes, indicate facility type and hours per week: □ Federal - Hours per Week _____ □ Non Federal - Hours per week _____

4. Discontinued any deliveries or any other medical activity in the last 10 years? □ **YES** □ **NO**

If yes, provide the following:

Discontinued Activity: _____

Applicant Name:_____ Date Discontinued: _____/_____
(MM/YYYY)

5. Have coverage for professional services under another professional liability policy? □ **YES** □ **NO**

If yes, provide the practice activity or service to exclude from your coverage:_____

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 Southern Cross Insurance Solutions policy will not provide coverage for VBACs performed in a home or in a non-clinical setting.**

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
6. **Had a newborn death within 7 days of life, stillbirth delivery or maternal death?** □ 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: ____ /_____

IV. 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
2. **Involved in a lawsuit; and/or,**
3. **Aware of any complication, event, incident or adverse outcome that might reasonably result in a claim or lawsuit?**

If yes, how many? _____

V. Roster of Staffing

Complete this section for Entity/Group Applicants Only.

A. Please identify all owners, employees and contracted individuals who provide, or have provided, professional services on behalf of the Entity/Group since the date the entity was formed or since the requested retroactive date, whichever is earlier, and provide all of the below information for each individual.

Last Name, First Name, M.I., Designation (i.e. Smith, Jane G., CNM)	**Status:** Owner Employee Ind. Contrac-tor	**Specialty**	**Training/Program/School Name**	**Grad. Date** (MM/YY)	**License #**	**Date of Birth** (MM/DD/YY)	**Hours per Week**	**Date Hired** (MM/DD/YY)	**Date Terminated** (MM/DD/YY)	**Retro Date** (MM/DD/YY)	**Coverage Needed?** (Yes or No)

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.

- □ $100,000 per claim / $300,000 annual aggregate
- □ $200,000 per claim / $600,000 annual aggregate
- □ $250,000 per claim / $750,000 annual aggregate
- □ $400,000 per claim / $1,200,000 annual aggregate
- □ $500,000 per claim / $1,500,000 annual aggregate
- □ $1,000,000 per claim / $3,000,000 annual aggregate
- □ Other: $ _____ per claim / $_____ annual aggregate

C. Prior Carrier Information: Provide information for all professional liability insurance companies that have provided coverage for the applicant for the past three 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 <u>different retroactive date,</u> from what is on the most recent declarations page, is being requested, please select one of the following:

□ 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 Southern Cross Insurance Solutions, will not provide Prior Acts coverage.

DI. Would you like to purchase General Liability coverage (Bodily Injury/Property Damage) for an additional charge? □ **Yes** □ **No**

DII. Are you required by contract to name an Additional Insured on your Professional and/or General Liability policy? □ **Yes** □ **No**

Please note that coverage is limited to the Additional Insured's vicarious liability based solely on professional services rendered by the affiliated Named Insured.

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: _____

Mailing Address: _____ _____ _____ _____ _____
Street Address Suite City State Zip Code

Nature of Professional Relationship to you: □ Landlord □ Employer □ Contracting Agency □ Other: _____

VII. Notices and Agreements

MANDATORY: ***ALL APPLICANTS must read and initial 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 (MM/DD/YYYY)
Agent/Producer Name	Agent License Number	

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SOUTHERN CROSS
INSURANCE SOLUTIONS

Southern Cross Insurance Solutions, LLC
P.O. Box 568428
Orlando, FL 32856

VIII. Supplemental Information

Southern Cross Insurance Solutions **APPLICANT(S) NAME:**_____
Orlando, FL

MULTI-SPECIALTY HEALTHCARE PROFESSIONAL

LOSS INFORMATION SUPPLEMENT

Please complete the following information for each applicant involved in each claim or incident. Please make copies if additional forms are needed for multiple claims or incidents and/or each applicant.

Note: Additional documentation may be requested at National Fire & Marine Insurance Company's discretion.

A. Is the matter related to A, B or C from the Loss Information section? (Check only one.)

- □ **A.** Current or prior claim.
- □ **B.** Complication, incident, or adverse outcome.
- □ **C.** Written request for records.

B. Is the matter identified in the Loss Information section related to (Check only one)**:**

- □ Professional Liability
- □ Other Commercial Liability, i.e. General Liability, EPLI, Cyber, etc. (please describe): _____

C. Patient/Claimant Information:

_____ _____ _____
Last Name First Name Age

D. Date of treatment and/or surgery which led, or could lead, to allegations against you: _____ / _____
(MM/YYYY)

E. Date of notice received, if applicable: _____ / _____
(MM/YYYY)

F. Has this matter been reported to your current or former insurer? □ Yes □ No

If Yes, date reported to your current or former insurer: _____ / _____
(MM/YYYY)

Current or former insurer name: _____

If No, please explain: _____

G. Name of all other doctor(s), hospital(s), surgery center(s) or healthcare provider(s), if any, involved: _____

_____

H. Current status: □ Open □ Closed
If open, indicate dollar value established by insurer: $ _____

If closed, date of closing: _____ / _____
(MM/YYYY)

Was a payment made? □ Yes □ No

1. If Yes, did you consent to the settlement? □ Yes □ No
2. Total amount of settlement or award: $ _____
3. Total amount of settlement or award paid on your behalf: $ _____

I. Nature of allegations or potential allegations:

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

J. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

_____

_____

K. What steps or procedures have you adopted to prevent a similar claim? Please explain:

_____

_____