SOUTHERN CROSS
INSURANCE SOLUTIONS

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 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

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Southern Cross Insurance Solutions home of The Midwife Plan

P.O. Box 568428, Orlando, FL 32856 Ann Geisler ext. #1 ageisler@southerncrossins.com
Phone: 407-985-3542 **Ann's Cell Phone: 407-491-4007**
Toll Free: 888-985-3542 Melanie Hart ext. #2 mhart@southerncrossins.com
Fax: 407-985-3556 Betty Hollis ext. #3 bhollis@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 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:

□ Sole Proprietor/Solo Incorporated
□ Owner of a Birthing Center
□ Employed or Contracted with a Midwife Group Practice
□ Other, please explain: _____
□ Employed or Contracted with a Hospital
□ Employed or Contracted with an OBGYN
□ Joining a National Fire & Marine Midwife Group Policy _____

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 National Fire & Marine 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**

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: ____ /_____
(MM/YYYY)

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**
   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?** □ **Yes** □ **No**
   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. Contractor	**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 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 <u>different retroactive date</u>, 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. Do you have a business entity or third party that you would like to add as an Additional Insured* on your Professional Liability policy? *Note that coverage is limited to the Additional Insured's vicarious liability based solely on professional services rendered by the affiliated Named Insured. □ **YES** □ **NO**

If yes, provide the information requested below. If you have more than one Additional Insured provide their name and practice address in Section VIII., Supplemental Information.

Additional Insured Name: _____

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

F. Would you like to purchase General Liability coverage (Bodily Injury/Property Damage) for an additional charge? □ **YES** □ **NO**

1. If yes, are you required by contract to name an Additional Insured on your General Liability Policy? □ **YES** □ **NO**

a. 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:_____

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	

VIII. 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:

_____

_____

_____

_____

_____