

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 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



Southern Cross Insurance Solutions home of The Midwife Plan

P.O. Box 568428, Orlando, FL 32856 Ann Geisler ext. #1 <u>ageisler@southerncrossins.com</u> 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 Marilyn Praytor ext. #3 mpraytor@southerncrossins.com

Emily Lacy direct (321)806-0018, emily@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

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

I GENERAL INFORMATION

	SENERAL INIORMATION					
Ini	DIVIDUAL APPLICANT:					
A.	Please check all that apply: □ Sole Proprietor/Solo Incorporated □ Owner of a Birthing Center □ Employed or Contracted with a M □ Other, please explain:	1idwife Group Pra	□ Employ	ed or Contracted with a red or Contracted with ar a National Fire & Marine	n OBGYN	up Policy
В.	First Name	- <u>м.і.</u> -	Last Name			Designation
						1
	Training/Program/School Nam	ie				Graduation Date
	Date of Birth	License/Co	rtification #	Hours Practicing	Por Wook	/
	Date of Biltii	License/Ce	i tilication #	riours Fracticing	PEI WEEK	Relibactive Date
	Phone	Email				
C.	List professional associations of	r societies of w	vhich you are a m	ember:		
D.	Do you need coverage for an el If yes, proceed to the Entity/G If no, proceed to Section II., P	ntity that you c roup Applicant ractice Inform	own? : Section below. ation.			□ YES □ NO
En	TITY/GROUP APPLICANT:					
A.	Please check all that apply: □ Professional Corporation: Sole Sh □ Partnership or Professional Assoc □ Limited Liability Company (LLC)/	ciation	□ Other, plea	al Corporation: Multiple Sase explain:		
В.						
	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 Ta	x I.D. Number	Date	Entity Formed	Entit	y Retroactive Date
C.	FOR GROUP APPLICANTS ONLY	/ :				
	Primary Contact Name				Tit	tle
	Phone	Email				
	- ·- -					

	actice Name o	of Primary Pr	actice Location			County	1
Street Address	5		<u>s</u>	uite City		State	Zip Code
2. Type of Fac	ility: □ Office	□ Hospital □	Birthing Center (Accredited) 🗆 E	Birthing Center (N	ot Accredited) Oth	er:
% of Pr	actice Name (of Practice Lo	cation			Co	ounty
Street Address	6		<u>_</u>	uite City		State	Zip Code
		- 11 - 2 - 1 -		-	District Control		-
3. Type of Fac % of Pi	ractico			(Accredited) 🗆	Birthing Center (Not Accredited) □ Ot	ner:
	Name	of Practice Lo	cation			Co	ounty
Street Address	<u> </u>		<u>_</u>	uite City		State	Zip Code
				-			•
For services r	endered in a pa	Stat	· · ·	•	ige in each state rcentage	e: 	
		Stat	<u> </u>	rG	rcentage		
Billing and Cor	respondence A	ddress: □ Lo	cation # (from Q	uestion A above	s): □	Other (Please enter I	below):
	•	ddress: □ Lo	, -		:):	`	,
Billing and Cor Street Addres	•	ddress: □ Lo	, -	uestion A above	:):	Other (Please enter l	below): Zip Code
Street Addres	s entity, or any a	pplicant requ	Suesting coverage	ite City		`	Zip Code
Street Addres Do you, your e 1. Provide tre	s entity, or any a eatment at a co	pplicant requ	Su esting coverage cility?	ite City e, or any of yo	our employees o	State r independent cont	Zip Code cractors:
Street Addres Do you, your e 1. Provide tre If yes, ind	s entity, or any a eatment at a co	pplicant requ rrectional fac pe and hours	Sility? per week: F	cite City e, or any of you	our employees o	State	Zip Code :ractors: Yes Hours per week
Do you, your of 1. Provide tree If yes, ind 2. Discontinu	entity, or any a eatment at a co icate facility ty ued any deliver	pplicant requ rrectional fac pe and hours ies or any otl	Su esting coverage cility?	cite City e, or any of you	our employees o	State r independent cont	Zip Code cractors:
Street Addres Do you, your e 1. Provide tre If yes, ind 2. Discontinu If yes, pro	entity, or any a eatment at a co icate facility ty ued any deliver vide the follow	pplicant requ rrectional fac pe and hours ies or any oth ing:	esting coverage cility? per week: Finer medical act	iite City e, or any of you ederal - Hours pointing in the lass	our employees o	State r independent cont Non Federal - I	Zip Code :ractors: YES Hours per week YES
Do you, your e 1. Provide tre If yes, ind 2. Discontinue If yes, pro	entity, or any a eatment at a co icate facility ty ued any deliver vide the follow d Activity:	pplicant requ rrectional fac pe and hours ies or any oth ing:	esting coverage cility? per week: Finer medical act	e, or any of you	our employees o	State r independent cont Non Federal - I	Zip Code :ractors: YES Hours per week YES
Do you, your of a second of the second of th	entity, or any a catment at a co icate facility ty ued any deliver vide the follow d Activity:	pplicant requ rrectional fac pe and hours ies or any oth ing:	Sility? per week: ner medical act	e, or any of you	our employees o	State r independent cont Non Federal - I	Zip Code :ractors: YES Hours per week YES

	Total	Last 1	2 Months	Next 12 Mon	ths
	Birthing Center Deliveries				
	Home Deliveries				
	Hospital Deliveries				
	Clinic Visits (excluding pregnancy visits)				
I	Family Planning/Well-Woman Care Visits				
	Of the total deliveries noted above, indicate how many are:	Last 1	2 Months	Next 12 Mon	ths
	VBACs performed in a Birthing Center				
	VBACs performed in a Home*				
	VBACs performed in a Hospital				
r	ndicate the total number of hours working ervices on behalf of you or the Entity/Grou	per week for all em	ployed and contra	cted individuals that will pro	vide profession
r	idicate the total number of hours working ervices on behalf of you or the Entity/Grou Healthcare Provider Birth Assistants	per week for all em p:	ployed and contra	cted individuals that will pro Total Hours per Week	vide professior
r	ervices on behalf of you or the Entity/Grou Healthcare Provider	per week for all em p:	ployed and contra	•	vide professior
F	ervices on behalf of you or the Entity/Grou Healthcare Provider Birth Assistants	per week for all em p:	ployed and contra	•	vide professior
[r	ervices on behalf of you or the Entity/Grou Healthcare Provider Birth Assistants Doulas	per week for all em p:	ployed and contra	•	vide profession
[r	Healthcare Provider Birth Assistants Doulas Student Midwives	per week for all em	ployed and contra	•	vide professior
56	Healthcare Provider Birth Assistants Doulas Student Midwives Massage Therapists Acupuncturists	per week for all em p:	ployed and contra	•	vide profession
	PROFESSIONAL INFORMATION	p:		Total Hours per Week	
H	Healthcare Provider Birth Assistants Doulas Student Midwives Massage Therapists Acupuncturists	ting coverage, or ar	y of your employe	Total Hours per Week	ors ever:
H 1	PROFESSIONAL INFORMATION Revices on behalf of you or the Entity/Grou Healthcare Provider Birth Assistants Doulas Student Midwives Massage Therapists Acupuncturists PROFESSIONAL INFORMATION Lave you, your entity, any applicant reques Been charged with, convicted of, or ind	ting coverage, or ar icted for any act co	ny of your employe mmitted in violation	ees or independent contractor on of any law or ordinance, ivileges denied, refused,	
H 1	Healthcare Provider Birth Assistants Doulas Student Midwives Massage Therapists Acupuncturists PROFESSIONAL INFORMATION lave you, your entity, any applicant reques Been charged with, convicted of, or ind other than traffic offenses? Had hospital privileges, DEA license, he revoked, suspended, restricted, subject	ting coverage, or ar icted for any act co ealthcare license or to a reprimand, pla	ny of your employe mmitted in violation	ees or independent contractor on of any law or ordinance, ivileges denied, refused,	ors ever:
H 1	Healthcare Provider Birth Assistants Doulas Student Midwives Massage Therapists Acupuncturists PROFESSIONAL INFORMATION lave you, your entity, any applicant reques Been charged with, convicted of, or ind other than traffic offenses? Had hospital privileges, DEA license, he revoked, suspended, restricted, subject	ting coverage, or ar icted for any act co ealthcare license or t to a reprimand, pla any kind? n that could impair	ny of your employed mmitted in violation reimbursement praced on probation the ability to prace	ees or independent contractor on of any law or ordinance, ivileges denied, refused, or voluntarily surrendered?	ors ever:

______ Date: _____ /____

Explanation: _

Applicant Name(s):____

IV. ROSTER OF STAFFING

Complete this section for Entity/Group Applicants Only.

Coverage Needed? (Yes or No) 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. Birth Assistants, Doulas, was formed or since the requested retroactive date, whichever is earlier, and provide all of the below information for each individual. Do NOT include: Birth Assistants, Doulas, Student Midwives, Massage Therapists or Acupuncturists UNLESS the individual is also trained and/or licensed as a Midwife, Nurse Practitioner or Naturopathic Physician. Retro Date (MM/DD/YY) Date Terminated (MM/DD/YY) Date Hired (MM/DD/YY) Date of Hours
Birth per
(MM/DD/YY) Week License # Grad. Date Training/Program/School Name Specialty Status:
Owner
Employee
Ind. Contractor Last Name, First Name, M.I., Designation (i.e. Smith, Jane G., CNM)

For and	the following section, include in	nformation for all types tv. A Loss Information S	of professional liability in	nsurance; e.g., malpractice	e; general liability; cy	ber/privacy liability;	
	Have you, your entity, any	•	• •	•	endent contractor	s ever been:	
	1. Involved in a claim e.g If yes, how many?		?			□ YES □ NO	
	2. Involved in a lawsuit? If yes, how many?					□ YES □ NO	
	3. Aware of any complica claim or lawsuit or had If yes, how many?	a request for a patier			sult in a	□ YES □ No	
	4. Involved in the treatmocooling after birth, result yes, how many?	iscitation after birth o	esulted in postpartun or maternal or fetal de	n hemorrhage, shoulder eath?	r dystocia,	□ YES □ No	
VI	. Coverage Information	N					
Clai bet cov	ims-Made coverage is limited ween the retroactive date and verage or the additional expense	generally to liability for expiration date of the po associated with an "ext	injuries for which clair olicy. Please contact yo ension contract(s)" or "t	ns are first made during ur agent should you have ail coverage".	the policy period, for any questions pertain	or services rendered ning to Claims-Made	
A.	Coverage Effective Date:	//	12:01 AM A	nnual policy terms will beg	in and end on the sa	me month/day.	
В.	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 \$5500,000 per claim / \$750,000 annual aggregate \$500,000 per claim / \$1,000,000 annual aggregate \$500,000 per claim / \$1,000,000 annual aggregate						
C.	Prior Carrier Information: the applicant for the last 3 years.	Provide information f ars. List "N/A" if there h	or all professional lia as not been coverage in	bility insurance compar the last 3 years.	nies that have prov	ided coverage for	
	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 co	verage was issued on	a Claims-Made basis	and a different retroac	tive date, from wh	at is on the most	
	recent declarations page, Not Applicable — the re An extension contract end An extension contract ere endorsement) from my current carrier w insured by my current ca Company, will not provide	is being requested, platroactive date being requested orsement (tail coverage) adorsement (tail coveraurent carrier where I arill result in an uninsured trier's policy. I undersi	ease select one of the uested is the same retro) has been or will be pur ge) has not and will n insured under a Claim exposure for any claims	efollowing: active date that I have wit chased. not be purchased. I wi so-Made policy. I realize the which may arise as a resi	h my current carrier. Il not purchase tail hat my failure to pur	coverage (reporting chase such coverage vices rendered while	
E.	Would you like to purchase If yes, are you required by					e? YES No YES No	
	mental Information.	icy, provide their name,	mailing address and nat	re than one Additional I ure of professional relatior	nship to you in Section	uired by contract n VIII., Supple-	
	Practice Address:			City		7: 6	
	Nature of Professional Re □ Lessor of Equipment □ Lessor of Premises –	elationship to you: – Rent or Lease Equipme Own, Rent or Lease Loca	ent – Description of Equi	pment:			

V. Loss Information

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 Agent/Producer Name Agent License Number VIII. SUPPLEMENTAL INFORMATION

VII. NOTICES AND AGREEMENTS

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

Gr	oup 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				
В.	What coverage type applies to the matter? (Professional Liability, General Liability,	EPLI, Cyber, etc.):			
_	Patient/Claimant Name				
C.	Patient/Claimant Name: First Name	Last Name			
D.	Date of treatment/incident: / /				
E.	Date you received notice of the matter:///////				
F.	Date reported to insurance company:///				
G.	Insurance Company Name:				
н.	Name of all other defendants, if any, involved:				
I.	Current status: Open Closed				
	If open, indicate dollar value established by insurance company: \$				
	2. If closed, date of closing: / /				
	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:				