EMPRO INSURANCE

Application

Nurse Midwives

Professional Liability Insurance

EmPRO INSURANCE COMPANY

Home Office: 1800 Northern Boulevard
Roslyn, New York 11576

Telephone: (516) 365-6345 (833) 774-6625
Fax: (516) 684-2365

Rochester Office: 1200C Scottsville Road, Suite 195
Rochester, New York 14624

Telephone: (585) 328-8860 (800) 329-8860
Fax: (585) 328-8686

PLEASE READ CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY

PLEASE PRINT or TYPE all information and make sure all questions are answered in full.

Incomplete or missing answers will cause delays in processing and may cause coverage to be declined.

If you have had claims or suits filed against you, please make certain you have a completed claims information form for each open suit or closed suit in the past 10 years.

Upon acceptance of your application you will be notified of premium due. Upon payment of the premium, your policy will become effective.

FOR ASSISTANCE, APPLICANT MAY CALL OUR HOME OFFICE AT ANY ONE OF THE NUMBERS LISTED ABOVE.

PROFESSIONAL LIABILITY POLICY APPLICATION
TO: EmPRO INSURANCE COMPANY

APPLICATION FOR NURSE MIDWIVES

Please note: Coverage is available on an Occurrence Basis only for Nurse Midwives

If my application is approved, make coverage effective on _____/_____/_____if possible, otherwise on any other date set by the COMPANY.

1. Applicant's Full Name: _____

☐ Male ☐ Female

Email Address: _____

a. Home Address: _____

b. Home Phone Number: _____

c. Name of Employer: _____

d. Address/Phone of Employer: _____

e. Employer Practices as: Individual Practitioner__☐__

Partnership__☐__

Professional Corporation _☐__

f. Name and Specialty of Supervising Physician:

_____

Name Specialty Policy Number

2. Social Security Number: _____

3. Date of Birth: _____

4. Professional Education

a. Name(s) and Address(es) of Nursing School(s):

_____

_____

_____

Date of Graduation: _____

b. Type(s) of Degrees, Diplomas and Certifications Received and Dates Acquired:

_____

_____

c. Name and Address of Nurse-Midwifery Training School:

_____

_____

_____

d. Type(s) of Degrees, Diplomas, and Certifications Received and Dates Acquired:

_____

_____

_____

5. Licensing

a. Current Nursing License Number: _____

State: _____ Expiration Date: _____

b. Are you New York State Certified to practice nurse-midwifery?

Yes ☐ No ☐

6. List all Continuing Education Units (CEUs) obtained in the last five years:

_____

_____

_____

7. Are you certified by the American College of Nurse Midwives?

☐ Yes ☐ No

If no, please explain: _____

If yes, Certification Number: _____

**** Please attach a copy of certification with application.***

Are you a current member in good standing of the American College of Nurse-Midwives?

☐ Yes ☐ No

If no, please explain: _____

8. What is the average number of hours per week you work as a nurse midwife? _____

a. What is your patient load per week? _____

b. How many hours per week are you on call? _____

9. Is your practice ☐ OB/GYN ☐ GYN only

Describe your practice:

_____

_____

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: _____

10. Are you associated with a: ☐ Hospital ☐ Birthing Center

☐ Other (Explain) _____

Name and Address:

_____

_____

Birthing Center License Number: _____

Are you an employee? ☐ Yes ☐ No

If no, please explain the nature of your privileges:

_____

_____

11. a. If your practice is OB/GYN, how many deliveries do you perform per year?

_____

_____

b. What percentages of your deliveries are routinely done in each of the following (must total 100%).

_____% Hospital _____% Birthing Center _____% Home

_____ Other (Explain) _____

c. Which method of natural childbirth do you practice? _____

d. Do you participate in the performance of Cesarean sections as part of your practice?

☐ Yes ☐ No

If yes, specify in what capacity:

_____

_____

12. Of your total practice, what percentage of time is spent for the following (must total 100%):

_____% Antepartum Care _____% Well Women Gynecology _____% Administrative

_____% Intrapartum Care _____% Postpartum Care ____% Family Planning

_____% Other, specify: _____

13. Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of any circumstances that might reasonably lead to such a claim or suit?
☐ Yes ☐ No

If yes, on a separate sheet, please provide complete details of each incident, including date, disposition, dollar amount of claims, and allegations (see page No. 6).

14. a. Have you ever appeared before a state regulatory or review committee for alleged misconduct or malpractice? ☐ Yes ☐ No

b. Has your license to practice nursing and/or nurse-midwifery ever been revoked, suspended or subjected to probation? ☐ Yes ☐ No

c. Has your membership in any nursing/medical/professional association ever been refused, suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No

d. Has any clinic, hospital, or birthing center, etc., ever suspended, restricted, or revoked your privileges? ☐ Yes ☐ No

e. Have you ever been convicted of any criminal charge? ☐ Yes ☐ No

If you answered YES to any of the above, please explain on a separate sheet of paper.

15. Current Insurance Coverage

a. Insurance Carrier: Name_____ Policy Number_____

b. Limits of Liability: _____

c. Policy Effective and Expiration Dates: _____

d. ☐ Deductible ☐ Self-insured Retention Amount $_____

e Coverage Type: ☐ Occurrence ☐ Claims-Made

Prior Acts Date: _____

f. Desired Effective Date of Coverage: _____

Enclose a copy of your current Declarations page (this page contains your name, address, insurance company's name and address, policy number and effective date, etc.).

16. Has your professional liability insurance ever been cancelled or non-renewed?
☐ Yes ☐ No

If yes, please explain: _____

17. a. Do you have a contract or consultation/collaborative agreement with a licensed practicing obstetrician? ☐ Yes ☐ No

b. Do you have a contract or consultation/collaborative agreement with a licensed practicing family practitioner? ☐ Yes ☐ No

c. Do you have documentation of the Informed Consent process according to ACNM standards? ☐ Yes ☐ No

d. Do you have written protocols that address the management of clinical issues, the management of emergency clinical issues, including transfer to physician?
☐ Yes ☐ No

e. When the patient's medical status changes from low risk pregnancy, do you have written plans that address: (1) the transfer of care to a physician; (2) notification of request for a medical consult; and (3) documentation of the process?
☐ Yes ☐ No

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE SUBMIT WITH THIS APPLICATION.

18. Is an EFM strip used to monitor every patient at the beginning of the evaluation of active labor (Baseline monitor strip)? ☐ Yes ☐ No

19. Do you maintain a current CPR certification for resuscitating both adult and neonatal patients?
☐ Yes ☐ No

20. You may appoint a policy administrator authorized to receive all communications, make requests and give instructions on your behalf with regards to your policy, except for consenting to settlement of a claim if such consent is required by the policy. Please identify the policy administrator by completing the below:

Name: _____

Title: _____

Address (mailing) _____

_____

_____

Phone _____
Fax _____
E-mail _____

Please make additional photocopies for each additional claim.

Claim Information

1. Name of Patient _____ 2. Age _____ 3. Sex _____

4. Allegation and your relationship to patient (e.g.: attending physician, primary surgeon, asst. surgeon, etc. _____
_____
_____

5. Date of Incident: _____ 6. Location:_____

7. Insurance Carrier: _____

8. Other Defendants: _____

9. Present Status: Open Claim ☐
Closed Claim ☐ Loss $_____Date Closed _____
Settlement _____ Judgment _____

10. Condition and diagnosis at time of incident:
_____
_____
_____

11. Dates and description of treatment rendered: _____
_____
_____

12. Condition of patient subsequent to treatment and DATES OF FOLLOW-UP TREATMENT
_____
_____
_____

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signed: _____ Date Signed: _____

I understand that in order to underwrite professional liability insurance, The COMPANY must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, underwriter, and insurance agent to furnish any information concerning me or my medical practice which the company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the COMPANY pursuant to this consent and direction, together with the agents, employees, or officers of such person or organization will not be liable to me in any way for furnishing such information, even though information is wrong.

I understand and agree that, if I am approved as a policyholder of the COMPANY and a policy is issued to me, that there is a continuing obligation on my part to update and keep current all of the information furnished by me as part of this application.

The application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant or the COMPANY to issue coverage.

This application shall be deemed appended to and a part of any policy of insurance issued to me based on this application.

My signature on this application shall be deemed to be a concurrent execution of the attached Subscriber's Agreement of Physicians' Reciprocal Insurers ("PRI"). I understand that in order to maintain my status as a policyholder of EmPRO Insurance Company, I must maintain my status as a subscriber of PRI. Termination of either contract shall result in the automatic termination of the other.

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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signature: _____ Date: _____
(Applicant's Signature)

_____
PRINT NAME

☐ **Please check box if you are submitting electronically only.**

☐ I fully understand that by checking this box I am accepting the terms and conditions stated above.

To be signed by the nurse midwife's supervising physician before insurance can be effected.

Certificate Required for **Certified Nurse Midwife** Applicant I understand that:

* EmPRO's policy provides coverage only when the nurse midwife is working in collaboration with and is performing the duties and responsibilities as assigned by the supervising physician.

* The duties and responsibilities of the nurse midwife must be within the scope and practice of the supervising physician who must be an obstetrician/gynecologist or a physician with obstetrical training and obstetrical privileges.

* I understand that as the employing physician, I certify that I will be the supervising physician of the Applicant.

* Mutually agreed upon written medical guidelines/protocol for clinical practice which confirms that ongoing communication will be in place between the supervising physician and the Certified Nurse Midwife, has been developed (must be submitted along with the application).

* Periodic and joint review and updating of the written medical guidelines/protocols by the supervising physician and certified nurse midwife will be conducted.

* Informed consent about the involvement of the supervising physician, Certified Nurse Midwife and other health care providers in the services offered is in place.

* Periodic and joint evaluation of services by supervising physician and Certified Nurse Midwife will be conducted.

_____

Signature - Supervising Physician

_____

Print Name - Supervising Physician

_____

Date