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

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

G. Coverage Options

Limits of Liability (Please check the desired limits of liability)

☐ $1,300,000 per claim/$3,900,000 Annual Aggregate

☐ $1,000,000 per claim/$3,000,000 Annual Aggregate

Select Coverage Type

☐ Claims-Made (A Claims-Made policy covers claims which arise and are made while the policy is in force.)

☐ Occurrence (An Occurrence policy covers you against any claim arising during your policy period irrespective when the claim is reported)

Prior Acts

If your expiring policy is on a Claims-Made basis, an extended reporting period endorsement (Tail Coverage) is generally available as an option of your expiring Claims-Made policy.

a. Are you purchasing extended reporting (tail) coverage from your prior carrier?

☐ YES ☐ NO

b. If yes, please provide proof of tail coverage. If no, please explain:

c. If no, do you want EmPRO to provide coverage for prior acts? ☐YES ☐NO

Prior acts coverage provides coverage for incidents which may have occurred but, as yet, no indication has been made to you that a patient will bring a claim/suit). **If yes, please complete the Conversion Supplemental information below and submit a copy of your most recent declarations page**.

Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.

a. Requested retroactive date _____.

b. Prior professional liability coverage was provided by _____
and it provided coverage from _____ to _____ on a claims-made basis, policy number _____.

c. Applicant is not, as of the date of this application, aware of any suits or claims against him that have not been reported to his prior carrier.

d. Applicant is not, as of the date of this application, aware of any conduct, circumstances or incidents which occurred while covered by his prior insurer that may give rise to any claims or suits.

e. Please include the names, policy numbers and coverage dates of any other claims-made policy held by you in New York State.

f. During any prior claims-made coverage period, have you ever altered your coverage to include a change in class, specialty, rate or territory?
Yes ☐ No ☐
If yes, please explain:
_____
_____
_____

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

PHYSICIANS' RECIPROCAL INSURERS
SUBSCRIBER'S AGREEMENT AND POWER OF ATTORNEY

This Subscriber's Agreement and Power of Attorney (the "Agreement") is made by and between Physicians' Reciprocal Insurers (hereinafter "PRI") and the "Subscriber," holder of an insurance policy, to which this Agreement is appended, issued by PRI or by a wholly owned subsidiary of PRI, subject to the approval of those insurance regulator(s) having jurisdiction over holders of policies issued by any subsidiary of PRI under the laws of states other than New York. For purposes of this Agreement, PRI and its wholly owned subsidiary are hereinafter, collectively, the Exchange.

WHEREAS, the Subscriber desires to participate as a subscriber of the Exchange pursuant to which PRI or its wholly owned subsidiary will issue policies of insurance.

NOW THEREFORE, the Subscriber hereby agrees as follows:

POLICIES OF INSURANCE

1. The Exchange shall issue non-assessable policies of professional liability insurance and ancillary general liability insurance to policyholders insuring against liability for claims arising from alleged incidents of malpractice.

ATTORNEY-IN-FACT

2. The Subscriber hereby designates and appoints PRIMMA LLC, a wholly owned subsidiary of PRI, ("PRIMMA") as the Attorney-in-Fact to act for and bind the Subscriber in all transactions relating to or arising out of the operations of PRI, subject to such limitations as may be lawfully provided, including, but not limited to, the issuance of non-assessable policies of professional liability insurance and ancillary general liability insurance issued to policyholders insuring against liability for claims arising from alleged incidents of malpractice on behalf of the Exchange as well as the authority to reinsure any portion of the policies of liability insurance issued by the Exchange as permitted by law.

3. The Subscriber hereby acknowledges and agrees that service of summons or other legal process on PRIMMA or on any persons appointed by PRIMMA to receive such process, shall, in any action, suit or proceeding arising out of any contract, agreement or transaction of the Exchange, be equivalent to personal service of such summons or other legal process on each and every Subscriber.

POWERS AND DUTIES OF PRIMMA

4. PRIMMA shall have the duty to provide all services necessary and appropriate to operate and administer the day-to-day affairs of PRI as provided by law and the Management Agreement between PRI and PRIMMA, including, but not limited to, marketing, procuring and underwriting insurance business; collecting premiums; and administering, investigating and defending claims arising from policies of insurance issued by the Exchange.

5. In April of each year, PRIMMA shall render to Subscribers a statement showing a summary of collective transactions of PRI during the preceding calendar year.

BOARD OF GOVERNORS

6. PRI shall be governed by an advisory committee, known as the "Board of Governors," which shall have ultimate power and responsibility for the management and control of the affairs of PRI. The Board of Governors shall consist of not less than nine persons elected by the Subscribers, at least two-thirds of whom are Subscribers or officers of Subscribers and not more than one-third of whom may be the Attorney-in-Fact or any person designated by the Attorney-in-Fact. Each member of the Board of Governors shall serve for a term of three years, and not more than one-third of the Board members shall be elected at each annual meeting of Subscribers.

7. There shall be an Annual Meeting of Subscribers held in New York State, a place and time to be chosen each year by the Board of Governors and designated in a Notice of Meeting sent to all Subscribers no less than 30 days prior to such meeting, and at which meeting each Subscriber shall have power to vote in person or by proxy for all members of the PRI Board of Governors to be chosen or appointed at such time. Each Subscriber will be sent a ballot which will contain the names and addresses of the Board of Governors' nominees.

8. At the Annual Meeting, the election of the Board shall take place and all ballots not returned shall be deemed to designate the Chairman as the proxy holder of the non-responding Subscribers. The Chairman will then conduct the election and certify the election of the nominated Subscribers.

9. A majority of the members of the Board of Governors shall constitute a quorum for the transaction of business.

10. If the Exchange should for any reason cease to grant insurance to a Subscriber member of PRI's Board of Governors, or their firm or corporation, such person shall thereupon cease to be a member of said Board.

11. No member of the Board of Governors shall as such incur any personal liability for any loss of any kind, from any cause, save only such loss as may be incurred by reason of their own malfeasance.

POWERS AND DUTIES OF THE BOARD OF GOVERNORS

12. The Board of Governors shall have full power and authority to:

    a. Adopt such rules and regulations for PRI and PRIMMA, as Attorney-in-Fact for PRI, not inconsistent herewith, as it shall see fit, including, but not limited to, fixing the compensation of PRIMMA, as the Attorney-in-Fact for PRI as provided in the PRI-PRIMMA Management Agreement, and directing PRIMMA in the safeguarding of all moneys and other assets and in making and changing of investments of PRI.

    b. Suspend, remove, and terminate PRIMMA, as Attorney-in-Fact, for good cause pursuant to the terms of the the PRI-PRIMMA Management Agreement.

    c. Fill any vacancy which may occur in the office of the Attorney-in-Fact at any time, by selecting and appointing a successor and executing thereto in the name and on behalf of each Subscriber such power of attorney, designation or other instrument as may be necessary or proper to enable it to act as Attorney-in-Fact with all the powers and authority herein given by the Subscribers to the aforesaid Attorney-in-Fact, without any further action on the part of Subscribers; and the Board of Governors shall mail to each Subscriber timely notice of each and every such change made.

    d. Fill for the unexpired term any vacancy which may occur for any reason in the Board of Governors.

    e. Fix its own fees from time to time within such limits as hereafter may be provided in the regulations adopted by it.

    f. Appoint sub-committees of the Board of Governors and delegate to such sub-committees authority to exercise any or all of its own powers except as herein otherwise provided.

    g. Fix the time and places of its own meetings.

    h. Elect officers, which shall include a Chairman.

    i. Select auditors who shall examine the books and accounts of PRI and report thereon to said Board.

    j. Call annual meetings or special meetings of Subscribers at any time, by mailing to the last known address of each timely notice thereof stating when and where said meetings are to be held.

    k. Determine what acts, incapacity or failure to act shall constitute a disqualification of any Subscriber to act further as such.

SUBSCRIBER RIGHTS, PRIVILEGES AND OBLIGATIONS

13. The Subscriber shall have the following rights, privileges and obligations as an underwriter of PRI, subject to the terms of the insurance contracts required or permitted by law to be issued:

    a. The Subscriber hereby agrees to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in the form and containing terms and conditions as are approved by the Exchange, but no Subscriber shall assume any liability as an insurer in any policy so granted.

    b. Upon application and acceptance, the Subscriber shall receive a policy of liability insurance and a copy of this Agreement appended thereto.

c. The Subscriber shall have the right to vote at all meetings of Subscribers, either in person or by proxy. All meetings of Subscribers shall be noticed by mail to all Subscribers not less than thirty (30) days prior to such meeting. The notice may include ballot materials concerning any matters requiring a vote at such meeting, which ballots must be completed and returned to PRI as noticed. On the scheduled date of a meeting of Subscribers, a vote on all previously noticed transactions shall take place and all ballots not returned shall be deemed to designate the Board of Governors, voting by a simple majority, as the proxy holder of the non-responding Subscribers.

d. The Subscriber reserves the right to revoke this Agreement and the Power of Attorney granted to PRIMMA herein as of the end of any calendar quarter upon written notice to PRIMMA.

e. In the event that PRI shall declare and make a Distribution to Subscribers and Non-Subscriber Policyholders, each Subscriber and Non-Subscriber Policyholder shall receive its Pro Rata Share of such Distribution. "Pro Rata Share" means, as of any date of determination, a percentage determined by dividing (i) the amount of annual premium payable under the Subscriber's or Non-Subscriber Policyholder's policy then in effect, by (ii) the total amount of annual premium payable under all policies issued by PRI and its subsidiaries then in effect, unless governing law provides otherwise. The date for determining the Pro Rata Share shall be established by the Board of Governors in conjunction with the authorization of any Distribution and shall, to the extent required, be approved by the New York State Department of Financial Services. "Distribution means a dividend, a cash payment, or any benefit inuring to Subscribers in conjunction with any restructuring of PRI. "Non-Subscriber Policyholder" means holders of policies issued by any subsidiary of PRI in a state in which policyholders are not permitted by applicable insurance law or regulation to be Subscribers, but have been allowed by applicable insurance law to economically participate in a Distribution as if they were Subscribers.

GENERAL PROVISIONS

14. PRI shall maintain a surplus to policyholders at least equal to the amount required to be maintained by Section 4103 of the New York Insurance Law for a similarly licensed stock property/casualty insurance company.

15. It is understood that the license of PRI and all other documents, data systems, books and records used in conducting the business of the Exchange are and shall remain the property of PRI.

16. This Agreement and the Power of Attorney herein contained shall supersede all previous Agreements and Powers of Attorney, if any, executed by all Subscribers, but any and all outstanding policies of liability insurance written under powers so superseded shall continue in full force and effect.

17. It is hereby expressly stipulated that this Power of Attorney shall be and hereby is strictly limited to uses contemplated by and expressed in this Agreement and no other.

18. All amendments, modifications or changes to this Agreement must be approved by the Board of Governors, may not be inconsistent with New York Insurance Law or any regulation thereto, and must be approved, in writing, by the Superintendent of the New York State Department of Financial Services prior to making such amendment, modification or change.

19. Every amendment, modification or change to this Agreement shall be submitted to all Subscribers contemporaneously in accordance with New York Insurance Law Section 6107(d)(4) and shall take effect as to all Subscribers who have not objected within sixty (60) days after the date of such submission. Failure of any Subscriber to object within sixty (60) days shall constitute such Subscriber's acceptance of such amendment, modification or change. Any Subscriber who objects, in writing, within sixty (60) days from the date of submission to such amendment, modification or change shall be deemed to have withdrawn from membership of the PRI and said Subscriber's liability insurance policy(s) with the Exchange shall be cancelled concurrent with such withdrawal.

20. In consideration of the foregoing, the Subscriber does hereby covenant and agree that Subscriber will fully and faithfully carry out, execute and perform everything in which PRIMMA shall, by virtue hereof, bind Subscriber, and in the same manner Subscriber does hereby ratify and confirm all that PRIMMA may lawfully do or cause to be done by virtue hereof.

21. This Agreement shall be governed by the laws of the State of New York.

22. Pursuant to Section 6106(a)(2) of the New York Insurance Law, the acceptance of a policy or binder of insurance with this Agreement printed thereon preceded by the words: "The acceptance of this policy or binder, shall constitute that execution and delivery by the insured of the Subscriber's Agreement, which is appended to this policy or binder, and hereby made a part thereof," shall constitute the execution and delivery of this Subscriber's Agreement by that insured as fully and to the same extent as though this Agreement has been signed and acknowledged by the insured.