

BIRTH CENTER
2014 APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE – CLAIMS MADE

POLICY LIMITS ARE \$1,000,000 EACH CLAIM / \$3,000,000 ANNUAL AGGREGATE

1. Name of Birth Center:
Address:

Email Address:
Phone:
Fax:

2. Policy Period: _____ to 1/1/2015

3. Please estimate the total number of deliveries at this birth center for the next 12 months:

Of this total, the number of deliveries attended by non-owners:

4. Billing preference: Annually Quarterly (\$5 per quarter billing fee) Monthly Automatic
If you are new to monthly, please complete EFT authorization at <http://washingtonjua.com/Forms.htm>
5. If you want to be billed with other policyholders rather than individually, please name the group/practice:
6. The insurance provided to the Birth Center will cover the Birth Center only. **Each licensee must have his or her own insurance.** Each midwife must complete an application for JUA coverage or provide evidence of existing insurance. Please list all midwives who will attend births at this center:
(please continue on separate sheet if more room is needed)

7. Name and Address of Birth Center Owner(s)
If renewing, complete only if there was any change in ownership in the past year:

8. Current insurance:

Professional Liability (if other than JUA)	General Liability
Insurance Company: _____	Insurance Company : _____ Effective Date: _____ Expiration Date: _____ Limit of Liability \$ _____ Deductible \$ _____

9. Prior History:

Are there any claims or lawsuits against you or the Birth Center in the last five years? No need to include information about claims the JUA has defended.

___Yes ___No If Yes, give details on a separate piece of paper.

10. Are there any circumstances of which you are aware which may give rise to a claim or a lawsuit?

___Yes ___No

11. Has any license or accreditation for the Birth Center ever been suspended, denied or revoked?

___Yes ___No

12. Has any company canceled or declined to renew insurance for you or for the Birth Center?

___Yes ___No

IF YOU ANSWERED "YES" TO ANY OF QUESTIONS 9-12, PLEASE PROVIDE DETAILS IN THE SPACE BELOW OR ON A SEPARATE SHEET OF PAPER.

APPLICANT REPRESENTATION, AUTHORIZATION AND RELEASE
(PLEASE READ CAREFULLY)

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of the underwriter in considering this application have been omitted. **I agree that this shall be the basis of the policy of insurance requested and that I will notify the Association of any changes contained herein.**

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications and competence including such other underwriting or claim matters as are deemed relevant, may be conducted by the Association or its duly authorized representatives. I expressly consent to any such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physicians, any prior insurance carriers, prior employers or professional associates and the Association or its duly authorized representatives. I hereby release and discharge the providers of information, the Association, its duly authorized representatives and the members or consultants of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by the Association or its duly authorized representatives.

I understand that Birth Center Facility Liability Insurance issued by the JUA **excludes coverage for** claims arising out of, relating to, in consequence of or in any way involving the following circumstances occurring at any insured birth center:

- Planned breech labors and/or deliveries**
- Labors and/or deliveries of known multiple births**
- Planned labors and/or deliveries influenced by Cytotec (mistoprol)**
- Planned VBAC labors and/or deliveries**
- Use of vacuum extractors or other instrumental delivery devices**

I acknowledge that this is not an exhaustive listing of exclusions and that the scope of coverage provided by the JUA, if any, is set forth in and is governed by the language of the insurance policy itself.

I UNDERSTAND THAT SIGNATURE OF THIS APPLICATION DOES NOT BIND THE
ASSOCIATION TO COMPLETE THIS INSURANCE.

Applicant's Signature

Date

(A photocopy of this Authorization shall be considered as effective and valid as the original)