Application for Limited Professional Liability Insured Midwife Paramedical Employee

ProAssurance American Mutual, A Risk Retention Group
PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • 205.877.4400 • Fax 205.868.4040

Date: _____ Policy #: _____ Expiration Date: _____ /_____ /_____

Name (Last, First, MI): _____

Home Address: _____ City: _____ State: _____ ZIP: _____

Current Employer: _____ Telephone Number: _____

Business Address: _____ City: _____ State: _____ ZIP: _____

1. Do you moonlight (work outside control of employer)? Yes ☐ No ☐
   If yes, where?

   _____

   _____

2. Do you have your own separate practice without a collaborating physician? Yes ☐ No ☐
3. Are you a member of any professional organization? Yes ☐ No ☐
   If yes, please list.

   _____

   _____

4. Does your supervising physician regularly review medical records and cases with you? Yes ☐ No ☐
5. Is your clinical competency validated by the physician? Yes ☐ No ☐
6. Will you be scheduled to work at a separate location from your supervising physician? Yes ☐ No ☐
   If yes, please give details on a separate sheet.
7. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession? Yes ☐ No ☐
8. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient? Yes ☐ No ☐
9. Do you order or perform diagnostic tests? Yes ☐ No ☐
10. Do you discriminate between normal and abnormal findings on the history, physical, examination diagnostic tests, initiate referrals and consultations when needed? Yes ☐ No ☐
11. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes ☐ No ☐
12. Do you perform a physical examination? Yes ☐ No ☐
    If yes, briefly describe techniques and instruments used: _____

    _____

13. Do you conduct informed consent discussions? Yes ☐ No ☐
14. Describe any other procedures, treatments, or duties you perform:

    _____

    _____

15. Do you provide any cosmetic procedures/services? Yes ☐ No ☐
    If yes, please indicate which procedures.

    ☐ Botox ☐ Derma Fillers ☐ Laser Hair Removal
    ☐ Microdermabrasion ☐ Laser Skin Resurfacing ☐ Sclerotherapy

16. Do you perform deliveries as a midwife? Yes ☐ No ☐

If yes, please answer the following questions:

A. How many deliveries do you perform annually? _____

B. Do you perform induction/augmentation? Yes ☐ No ☐

C. Do you perform assisted Vaginal Deliveries? Yes ☐ No ☐

If yes, is the physician present? Yes ☐ No ☐

D. Do you perform VBAC deliveries? Yes ☐ No ☐

If yes, is the physician present? Yes ☐ No ☐

E. Do you perform underwater births? Yes ☐ No ☐

F. Do you perform home or birthing center deliveries? Yes ☐ No ☐

G. As a mid-level provider do you follow alternative birthing plans? Yes ☐ No ☐

If yes, please describe: _____

17. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice:

_____

_____

18. Please list all states in which you are licensed along with each license number and renewal date:

State	License Number	Renewal Date

19. I have noted below and agree to notify the Company going forward of any of the following events within thirty (30) days of its occurrence: (Please note any circumstances below under Additional Comments)

A. Change in my medical procedures performed, practice location, or the scope of my practice;

B. Complaint, grievance, investigation, restriction, suspension, or surrender of any state medical license, DEA license, or hospital privileges;

C. Investigation of my Medicare/Medicaid billing procedures;

D. Any physical or mental condition or illness, including treatment for alcohol or substance abuse or any accusation of sexual misconduct or inappropriate contact not previously disclosed to the Company in writing;

E. Conviction, plea, or agreement related to any charges or a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses;

F. A claim or suit for alleged malpractice has been made against me and reported to another insurance carrier or hospital self-insured trust, or if any claim or suit resulted in payment by me or on my behalf, since I became an insured of a ProAssurance company.

I acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy. Failure to notify the Company of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Risk Management Agreement Language

I agree that my office staff and I will comply with all Ob-Gyn Risk Alliance risk management programs administered by ProAssurance companies. Our compliance includes cooperating with ProAssurance and its employees and independent contractors in all risk management assessments and recommendations, participating in educational programming, and committing to work with the Ob-Gyn Risk Alliance to improve patient care and thus reduce losses.

I agree to ensure that my staff will work to further such risk management collaboration and comply with all education and risk management improvement recommendations.

I understand that compliance with this statement is necessary for membership in the Ob-Gyn Risk Alliance Purchasing Group, and failure to comply may jeopardize further participation in the program.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Consent to Conditions of Consideration of the Application for Insurance

I understand that no coverage will be bound until after ProAssurance has reviewed my completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, my advance payment will be promptly returned to me.

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me.

To the fullest extent permitted by law, I extend absolute immunity to and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I understand that should any incident, injury or death occur to any patient while under my care subsequent to my signing and dating this application, I must notify ProAssurance or its authorized agent or broker in writing of such event.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following section is an Applicant's Representation and Authorization from which requires your signature. Please read carefully.

Applicant's Representation and Authorization

I, the undersigned, hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon my acceptability to ProAssurance and its subsidiaries or agents as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I understand that third-party information, records or data regarding my practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name and Title (Printed): _____

Applicant's Signature: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Insured Physician's Authorization

I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I understand that such coverage is subject to underwriting approval.

Requested Effective Date: _____

☐ Shared Limits Coverage

☐ Separate Limits Coverage

_____ _____

Signature of Insured Physician/Supervising Physician Date

_____

Please Print Name

Proxy for ProAssurance American Mutual, A Risk Retention Group Applicants

In consideration of ProAssurance American Mutual, A Risk Retention Group's issuance of insurance to the Applicant, the Applicant hereby constitutes and appoints the Chairman of the Board of ProAssurance American Mutual, A Risk Retention Group as the Applicant's proxy to attend all meetings of the members of ProAssurance American Mutual, A Risk Retention Group, with full power to vote as proxy for the Applicant and act in the Applicant's name, place and stead, in the same manner, to the same extent, and with the same effect that the Applicant might if personally present, giving to the Chairman of the Board full power of substitution. This grant of a proxy shall continue in force indefinitely until either (1) the Applicant ceases to be a policyholder of ProAssurance American Mutual, A Risk Retention Group or (2) the Applicant revokes the proxy.

THE APPLICANT MAY REVOKE THIS PROXY AT ANY TIME BY ATTENDING A MEETING OF THE MEMBERS OF PROASSURANCE AMERICAN MUTUAL, A RISK RETENTION GROUP OR BY SENDING PROASSURANCE AMERICAN MUTUAL, A RISK RETENTION GROUP A WRITTEN NOTICE REVOKING THE PROXY.

_____
Name of Applicant

_____
Signature of Applicant or Authorized Officer

_____
Print Name

_____
Title

_____
Date