JUA **Joint Underwriting Association for Midwifery and Birthing Centers Malpractice Insurance**

PO Box 2676
Redmond, WA 73-2676
(866) 415-6061 Fax: (866) 212-9633

BIRTH CENTER
2009 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:______________________________

   Street Address:______________________________

   City:____________ State:_____ Zip:____________ County:____________

   Email Address:____________ Phone:____________ Fax:____________

2. Policy Period: From:____________ To: **1/1/2010**

3. Department of Health Child Birth Center License No.: ____________

4. Birth Center Status ___Not For Profit ___For Profit

5. Number of Years in Operation:____________

6. Please estimate the total number of deliveries at this birth center for the next 12 months or provide the total number of births at this Birth Center in the past 12 calendar months: ____________

   Of this total, the number of deliveries attended by Birth Center owner: ____________

   Of this total, the number of deliveries attended by other than owner: ____________

7. After the patient is admitted to the Birth Center, is an appropriate staff member continuously present? ___Yes ___No

8. The insurance provided to the Birth Center will cover the Birth Center only**. Each licensee must have his or her own insurance**. Each licensed 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)*

Midwife Name:	License No.	Insurer & Policy #

9. Name and Address of Owner(s):

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10. Current insurance:

Professional Liability (if other than JUA)	**General Liability**
Insurance Company:________________________ Effective Date:________Expiration Date:_________ Limit of Liability:___________________________ Deductible $_______________________________ Occurrence Form ______ or Claims Made ______ If Claims Made, the Retroactive Date:___________	Insurance Company :__________________________ Effective Date:________ Expiration Date:_________ Limit of Liability $___________________________ Deductible $___________________________________ Occurrence Form ______ or Claims Made______ If Claims Made, the Retroactive Date:___________

11. Prior History:
Are there any claims or lawsuits against you or the Birth Center in the last five years?

___Yes ___No If Yes, give details below:

Date of Incident	**Amount Paid or Reserved**	**Claimants Name & Description of Incident**

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

___Yes ___No

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

___Yes ___No

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

___Yes ___No

15. Please use this section for explanation of any YES answers to questions 9 through 11:

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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 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)