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

PO Box 2676
Redmond, WA 98073-2676
(866) 415-6061 Fax: (866) 212-9633

MIDWIFERY
2012 APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE – CLAIMS MADE
POLICY LIMITS ARE $1,000,000 EACH CLAIM / $3,000,000 ANNUAL AGGREGATE

1. Applicant Name:

   Policy Number:

   Address:

   Email Address:
   Phone:
   Fax:

2. Policy Period: _____ to **1/1/2013**

3. Estimate how many deliveries you expect to perform in WA State during this policy period. ☐
   Please give one number—not a range--since this number is used to calculate your premium.
   Do not include out-of-hospital VBAC, breech, or multiples as those are not covered by the JUA.

4. If you are an ARNP, what percentage of your practice is Well Woman GYN Care? ☐

5. Estimate how many deliveries you expect to perform *outside* WA State during this policy period ☐
   The JUA only covers you for care provided within WA State, so these deliveries will not be counted

6. List states other than WA State where you are licensed as a midwife: _____

7. If new application, date you began or will begin your midwifery practice:_____

8. You need 10 hours of continuing education for each full year of JUA coverage. **You must attach Certificates of Completion** in order for the hours to be credited**.** No need to resubmit certificates the JUA already has on file. Do not submit CPR, NRP or Peer Reviewer hours.

9. Name of the WA State Department of Health "Coordinated Quality Improvement Program" (CQIP) you participate in for peer review:
   ☐ MAWS ☐ PMA ☐ Other _____

   Unless you are new to practice, **you must include a copy of a 2010 or 2011 Certificate of Participation in peer review.** No need to resubmit certificates the JUA already has on file.

   If you are employed by a Hospital or Community Health Center, include a letter from the Administrator or Medical Director stating you actively participate in the facility's peer review program.

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10. List all midwives who are involved in your practice, either as partners or back-up coverage:

11. List all other licensed or unlicensed care providers you employ, contract, or enlist in your practice:

Name:	Role in Your Practice	Licensed? / Insured?

12. 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

13. If you want to be billed with other policyholders rather than individually, please name the group/practice:

14. Are you currently insured for professional liability for anything other than midwifery? ___Yes ___No

Name of Carrier:_____ Practice Specialty:_____

15. In the last year have you had a mother/patient or family member:

a. Make an allegation against you for unprofessional conduct or malpractice? ___Yes ___No
b. Make a claim against you for unprofessional conduct or malpractice? ___Yes ___No
c. File a suit against you for unprofessional conduct or malpractice? ___Yes ___No
d. Receive payment due to a claim for unprofessional conduct or malpractice? ___Yes ___No

16. Are you aware of any matters or complaints regarding your care currently under review or investigation by any licensing or discipline authority? ___Yes ___No

17. In the last year have you:

a) Been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ___Yes ___No
b) Incurred or become aware of having an illness or disability that impairs or could impair your ability to practice your specialty? ___Yes ___No
c) Had a state professional license or a state or federal license to prescribe narcotics refused, suspended, revoked or accepted a license renewal on special terms or voluntarily surrendered the same? ___Yes ___No
d) Had any other malpractice insurance carrier decline, cancel, or renew under special terms only? ___Yes ___No

18. Do you prescribe, dispense or administer any prescription medications used to produce cervical ripening, induction or initiation of labor, or augmentation of labor in an out-of-hospital setting? ___Yes ___No

IF YOU ANSWERED "YES" TO ANY OF QUESTIONS 15-18, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET OF PAPER.

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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 Midwifery Liability Insurance issued by the JUA **excludes coverage** for claims arising out of, relating to, in consequence of or in any way **involving the practice of the Midwife as a Naturopath** as well as any of the following circumstances occurring out-of-hospital:

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.

Applicant's Signature _____ Date _____

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

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