Ob-Gyn Risk Alliance

Medical Corporation Professional Liability Insurance Renewal Application

ProAssurance American Mutual

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: _____

Important: Please review, complete, and return this renewal application with the physician renewal application. Make any necessary changes to the pre-filled information below. Your prompt, accurate reply assists your policy's renewal. Thank you.

1. Organization Information

Organization Name: _____

Federal Tax ID Number: _____-_____

Primary Office Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Preferred Billing Address: _____

Contact Name: _____ Title: _____

Phone: _____ Email: _____

Is this contact the authorized representative for access to policy information at ProAssurance.com? Yes ☐ No ☐

If no, please provide the name of the policy's authorized representative: _____

Please list any additional practice locations (if more than one, list those on last page):

Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

A. Type of Corporation

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership
☐ Multi-shareholder Corporation ☐ Limited Liability Corporation ☐ Other: _____

B. Has the Organization ever been incorporated under a name other than that listed above? Yes ☐ No ☐
If yes, please list all previous names and the first use date of each:

_____

C. Is or has the Organization ever been incorporated in a state other than that listed above? Yes ☐ No ☐
If yes, please list states and first use date in each:

_____

D. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐
If yes, please list all d/b/a names:

_____

E. List other separate entities for which coverage is requested (if not listed above):

_____

_____

2. Professional Liability Insurance and Claims History

i. Has any pending or open claim, suit or incident previously reported to another carrier prior to becoming insured by ProAssurance resulted in any payment, judgement or settlement of any kind? Yes ☐ No ☐

3. Practice Information

A. List all physicians who will be *insured elsewhere* and provide proof of coverage. Please provide explanation in the space provided at the end of the application.

Name	Specialty	Current Insurer

B. List all paramedicals who will be *insured elsewhere* and provide proof of coverage.

Name	Specialty	Current Insurer

*Paramedicals include a person practicing as a nurse midwife, nurse anesthetist, nurse practitioner, physician assistant, surgical assistant, cytotechnologist, or any person licensed, certified or otherwise authorized to deliver advanced level healthcare in the absence of direct supervision by a licensed physician.

C. Do physicians/individuals not affiliated with your organization use your facilities and/or equipment? Yes ☐ No ☐

D. Is the organization or any member physician whole or part owner in any medical professional joint venture outside of this practice? Yes ☐ No ☐

If yes, please describe in the space provided at the end of the application.

E. Is this organization considered a medical spa? Yes ☐ No ☐

4. Hospital Affiliations and Privileges of the Organization

A. Please list all hospitals where you have active privileges or a pending application.

Hospital 1 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____

Hospital 2 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____

Hospital 3 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____

Hospital 4 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____

B. Does your hospital require physician(s) to remain in-house for VBAC patients? Yes ☐ No ☐

If yes, which hospital(s)? 1 2 3 4

C. Are fetal monitoring strips stored digitally? Yes ☐ No ☐

If yes, which hospital(s)? 1 2 3 4

D. Can the physician(s) remotely view the hospitals' electronic fetal monitoring (EFM) strips? Yes ☐ No ☐

If yes, which hospital(s)? 1 2 3 4

E. Does the hospital require physicians to have EFM interpretation certification to grant OB privileges? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

F. Do any of these hospitals use laborists? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

G. Does each of the hospital(s) where the physicians deliver require specialty specific certification for their perinatal nurses? Examples include: the Neonatal Resuscitation Program (NRP), the Association for Women's Health, Obstetric and Neonatal Nursing (AWOHNN certification), fetal monitoring, or the Advanced Practice Strategies fetal monitoring course. Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

H. Do physicians and nurses have regularly scheduled case study discussions or training opportunities? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

I. Are debriefings performed when unanticipated clinical outcomes occur? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

J. Have any of the hospital(s) where the physician(s) deliver adopted Institute of Healthcare Improvement's (IHI's) Elective Induction Safety Bundle? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

K. Have any of the hospitals where the physicians deliver adopted IHI's Elective Augmentation Safety Bundle? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

L. What is the maximum amount of time it takes to perform an emergency C-section once it is determined that one is necessary?
Hospital 1: _____ minutes
Hospital 2: _____ minutes
Hospital 3: _____ minutes
Hospital 4: _____ minutes

M. Please answer the following question regarding access to a C-section/Anesthesia team:

Hospital 1: Is there a C-Section/Anesthesia team on site? Yes ☐ No ☐
If no, indicate the team's response time when called: _____

Hospital 2: Is there a C-Section/Anesthesia team on site? Yes ☐ No ☐
If no, indicate the team's response time when called: _____

Hospital 3: Is there a C-Section/Anesthesia team on site? Yes ☐ No ☐
If no, indicate the team's response time when called: _____

Hospital 4: Is there a C-Section/Anesthesia team on site? Yes ☐ No ☐
If no, indicate the team's response time when called: _____

N. Do the hospital(s) routinely schedule the following obstetrical emergency drills? Yes ☐ No ☐
If yes, which hospital(s)?

Dystocia Drills: 1 2 3 4

Maternal CPR: 1 2 3 4

Clinical Simulation Training: 1 2 3 4

O. Is EFM performed on active labor patients? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

P. Are placentas maintained for at least seven days post-delivery? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

Q. Is structured communication (e.g., SBAR) used between physicians and nursing staff to relay patient information? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

Fraud Warning – The Organization acknowledges the applicable fraud warning for its 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

On behalf of the Organization, I understand that no coverage will be bound until after ProAssurance has reviewed this 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, any advance payment will be promptly returned to the Organization.

On behalf of the Organization, I accept the following conditions during the processing and consideration of this application—regardless of whether or not granted insurance—and for the duration of the insurance which may be issued.

To the fullest extent permitted by law, I, on behalf of the Organization, 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 this 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.

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

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Title: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage.

Applicant's Representations and Authorization

I, the undersigned, on behalf of the Organization, hereby authorize present and prior professional liability carriers, any and all attorneys who have represented us in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding the Organization, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon our 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.

On behalf of the Organization, I understand that third-party information, records or data regarding our practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

On behalf of the Organization, 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.

On behalf of the Organization, 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.

On behalf of the Organization, 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 (Printed): _____

Applicant's Signature: _____ Date: _____

Title: _____

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

For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

Please attach additional sheets as necessary.

Proxy for Existing
ProAssurance American Mutual, A Risk Retention Group Members

In consideration of the ProAssurance American Mutual, A Risk Retention Group's issuance of insurance to the Insured, the Insured hereby constitutes and appoints the Chairman of the Board of ProAssurance American Mutual, A Risk Retention Group as the Insured'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 Insured and act in the Insured's name, place and stead, in the same manner, to the same extent, and with the same effect that the Insured 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 Insured ceases to be a policyholder of ProAssurance American Mutual, A Risk Retention Group or (2) the Insured revokes the proxy.

THE INSURED 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.

_____
Insured

_____
Signature of Insured or Authorized Officer

_____
Print Name

_____
Title

_____
Date