Hospitals Insurance Company, Inc.

Voluntary Attending Physicians Application for Professional Liability Insurance Supplement for Obstetricians

Please return this supplemental application, with your completed Application for Professional Liability Insurance, a copy of your New York State license and a copy of your declaration page from your previous carrier (if applicable), in the enclosed business reply envelope.

Obstetricians must have admitting privileges at a participating hospital (Beth Israel Medical Center, Maimonides Medical Center, Montefiore Medical Center, Mount Sinai Medical Center) to be eligible for coverage.

If your application is approved, coverage can begin the day following the postmark on the return envelope containing your completed and signed application, or later if you choose.

General Information

1. Name _____ ☐ MD ☐ DO
LAST FIRST MIDDLE

2. Check participating hospital
☐ Beth Israel Medical Center
☐ Maimonides Medical Center
☐ Montefiore Medical Center
☐ Mount Sinai Medical Center

Supplemental Information

Please indicate the following:

PROCEDURE	NUMBER PERFORMED OVER THE PAST 12 MONTH PERIOD
Deliveries	
Cesarean Sections	
Forceps Deliveries	
Vacuum Assisted Deliveries	
VBACs	
Multiple Gestation	
High Risk Deliveries (including, but not limited to, mothers who are diabetic, over age 35, or have had previous miscarriage(s))	

over

Supplemental Information *continued*

In connection with this supplemental application, I represent and warrant to Hospitals Insurance Company, Inc. (HIC) that, at all times while insured by HIC, I will:

1. adhere to the attached Consensus Best Practices for Obstetrics (Best Practices Guidelines), which have been adopted by the participating hospitals in consultation with HIC;
2. participate in any and all training, education and/or risk management programs that may be mandated from time to time by the Best Practices Guidelines;
3. participate in, and/or facilitate the participation by me or my practice in, periodic audits and/or inspections of my practice and adherence to the Best Practices Guidelines;
4. participate in, and/or facilitate the participation by me or my practice in, the sanctions that may be imposed from time to time for failure to adhere to, or other infractions of, the Best Practices Guidelines;
5. adhere to all other guidelines and/or risk management procedures applicable to the specialty of obstetrics or to the medical staff established or required by my participating hospital; and
6. complete and pass the HIC Fetal Heart Monitoring Course pursuant to HIC's rules and regulations.

Release and Authorization

I understand and agree that this representation and warranty is a part of my application for Professional Liability Insurance and will be relied upon by HIC for the purpose of issuing coverage and that, if my application is approved by HIC, this representation and warranty is material to HIC's agreement to provide the Professional Liability Insurance applied for herein.

SIGNATURE OF APPLICANT

DATE OF SIGNATURE

FULL NAME (PLEASE PRINT)

NOTE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND WILL INVALIDATE YOUR INSURANCE COVERAGE.

All coverage is subject to the terms, conditions, and exclusions contained in the policy.