Supplemental Application for Professional Liability Insurance for Obstetricians, Certified Midwives and Certified Nurse Midwives

Please return this supplemental application with your completed application for Professional Liability Insurance, a copy of your New York State professional license and a copy of the declaration page from your current professional liability insurance carrier.

General Information

1. Name ____
LAST FIRST MIDDLE

☐ MD ☐ DO ☐ CM ☐ CNM

2. License#: ________________

Supplemental Information

Please indicate the following:

Procedure	Number Performed Over the Past 12 Months
Births	
Cesarean Sections (Physicians only)	
Forceps Deliveries	
Vacuum Assisted Deliveries	
VBACs	
Multiple Gestations	
High Risk Deliveries [including, but not limited to, mothers who are diabetic, over age 35, or have had previous miscarriage(s)] (Physicians only)	

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:

1a. adhere to the attached Clinical Practice Guidelines/Best Practices Guidelines (Best Practices Guidelines), which have been adopted by the sponsor hospitals in consultation with HIC;

1b. 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;

1c. submit to, and/or facilitate the submission by me or my practice to, periodic audits or inspections of my practice and adherence to the Best Practice Guidelines; and

1d. submit to, and/or facilitate the submission to me or my practice to, the imposition of the sanctions that may be imposed from time to time for failures to adhere to, or other infractions of, the Best Practices Guidelines, subject to the applicable sanctions procedures set forth in the Best Practices Guidelines; and

2. adhere to all other guidelines and/or risk management procedures applicable to the specialty of obstetrics and established and/or required by my sponsor hospital; and

3. complete and pass the HIC Fetal Heart Monitoring Course pursuant to the rules and regulations promulgated therefor by HIC.

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 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.