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

JUA@WendyGordonConsulting.com
Tel: (425) 536-8227

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE – CLAIMS MADE

POLICY LIMITS ARE $1,000,000 EACH CLAIM / $3,000,000 ANNUAL AGGREGATE

1. Applicant Name: _____
   (First Last, Credentials)

   Address: _____

   Email Address: _____

   Phone / Fax: _____ Date of birth: _____

   Midwifery school: _____ Grad year: _____

   WA Midwife License Number: _____ Exp. Date: _____

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

3. If new application,
   a. date you began (or will begin) practice in WA State: _____
   b. first date you were licensed as a midwife in any state? _____

4. Policy Period: **1/1/20__ or ___/___/20___** to **1/1/20____(All policies renew on January 1)**

5. 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 VBACs, breeches, or multiples as those are not covered by the JUA.

6. If you are an ARNP, what **percentage** of your practice is well-person GYN care? ☐

7. 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

8. Select which pricing you are applying for (New applicants are only eligible for "Regular"):
   - ◉ Regular
   - ○ Sabbatical. Dates: _____ (Only applicable if doing < 12 births)
   - ○ Short term practice reduction (for < 12 births, licensed for 5+ yrs, current JUA policy for 5+ yrs)
   - ○ Long term practice reduction (for 0 births, licensed for 10+ yrs, current JUA policy for 5+ yrs)

9. Billing preference:
   - ○ Annually
   - ○ Quarterly ($5 per quarter billing fee)
   - ○ Monthly: Automatic credit card billing or EFT bank transfer

   If you are new to monthly, please complete EFT/Credit Card Authorization Form (attached). If you would like to pay by credit card, please complete the attached EFT/Credit Card Authorization Form. Credit card transaction fees will be charged. Only monthly payments are eligible for EFT.

10. If a practice is paying your premiums, please list the group/practice: _____

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11. **Renewals only**: If you completed a B.E.S.T. or ALSO Emergency Skills Training Course in the current policy year, you may be eligible for a credit on your next policy premium in the amount of the cost of the course.

    Include the following with your application:
    - ☐ a copy of your Certificate of Completion
    - ☐ receipt for the course

    This credit is available to you once every two years.

12. **Renewals only**: You must submit 10 hours of **continuing education** for each of the last three calendar years of JUA coverage (10 hours per year).

    Include the following with your application:
    - ☐ a copy of your Certificates of Completion

    No need to resubmit certificates the JUA already has on file. Do not submit CPR, NRP or Peer Reviewer hours.

13. **Renewals only**: You must participate in **peer review** at least once every two calendar years. The peer review must be approved by the WA State CQIP, most likely through MAWS, WARM, or PMA**.**

    Include the following with your application:
    - ☐ a copy of your Certificates of Participation

    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 Administration or the Medical Director stating you actively participate in the facility's peer review program.

14. **All applications:**

    Include the following with your application:
    - ☐ a copy of your NRP card (not CE certificate)

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

Name:	Role in Your Practice	Licensed?	Insured?

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

Name:	Role in Your Practice	Licensed?	Insured?

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17. Are you currently insured for professional liability for anything other than midwifery? ◯Yes ◯No

    If yes, name of carrier:_____ Practice Specialty:_____

18. In the last year have you had a client 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

19. Are you aware of any matters or complaints regarding your care currently under review or investigation by any licensing or discipline authority? ◯Yes ◯No

20. 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

21. Do you prescribe, dispense or administer any prescription medications used to produce cervical ripening, induction or initiation of labor, or augmentation of labor in a home or freestanding birth center setting? ◯Yes ◯No

22. Have you ever had a claim or lawsuit brought against you for which an indemnity payment was made? ◯Yes ◯No

    If yes, and were insured for the claim with an insurer other than the Washington JUA, please provide us with a loss history report/loss run from that insurer.

IF YOU ANSWERED "YES" TO ANY OF QUESTIONS 17-21, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET.

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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 (misoprostol),
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.

I acknowledge that pursuant to WAC 284-87-090, WAC 284-87-110 and WAC 284-87-120, coverage is offered to a licensee if the licensee is judged to be an acceptable insurable risk. Policies written by the association will not automatically renew. To obtain continuing coverage by the association, a licensee must again satisfy initial eligibility requirements under WAC 284-87-090 at the end of the expiring policy term.

I acknowledge that policies can be canceled for non-payment of premiums or with prior written approval of the commissioner upon the request of the board, for cause, which would have been grounds for refusal of coverage under WAC 284-87-090. Acceptable standards include implementation of risk consultation recommendations. Pursuant to RCW 48.87.080 a risk management program for insureds of the association must be established as a part of the plan. This program must include but not be limited to: Investigation and analysis of frequency, severity, and causes of adverse or untoward outcomes; development of measures to control these injuries; systematic reporting of incidents; investigation and analysis of patient complaints; and education of association members to improve quality of care and risk reduction.

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I acknowledge that policies are the property of the named insured/policyholder. Only the named insured/ policyholder can request coverage changes or termination of coverage. The named insured/policyholder is ultimately responsible for payment of premiums regardless of any payment arrangements otherwise made.

Premiums can increase based upon risk and claim history.

Applicant's Signature: _____ Date: _____

Applicant's Printed Name: _____

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

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

BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT and commitment is executed by Wendy Gordon Consulting, LLC hereinafter referred to as "Business Associate".

Recitals

Business Associate and the insured have a relationship by virtue of a professional liability policy issued by the Washington State Joint Underwriting Association to the insured, hereinafter, "Insurance Policy". Business Associate is contracted by the Washington State Joint Underwriting Association as a Third Party Administrator. Business Associate and the named insured are committed to complying with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under the Privacy Regulations, the insured is a "covered entity", and, as defined by 45 C.F.R. §164.502(e) and 45C.F.R. §164504(e), Wendy Gordon Consulting, LLC is a business associate of the insured. Business Associate must use and/or disclose Protected Health Information in its performance of services under the Insurance Policy. Business Associate agrees to abide by the assurances, terms, and conditions contained herein in the performance of its obligations. This Agreement sets forth the manner in which Protected Health Information, that is provided to, or received by, the Business Associate from the insured, or on behalf of the insured, will be handled.

The Business Associate agrees as follows:

Section 1: Definitions

1.1 Business Associate: "Business Associate" shall mean Wendy Gordon Consulting, LLC

1.2 Covered Entity: "Covered Entity" shall mean the insured.

1.3 Designated Record Set: "Designated Record Set" means "Designated Record Set" as defined in 45 C.F.R. §164.501.

1.4 Individual: "Individual" shall have the same meaning as the term "Individual" in 45 C.F.R. §164.501 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g)

1.5 Privacy Rule: "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. parts §160 and §164 subparts A and E.

1.6 Protected Health Information (PHI): "Protected Health Information" (PHI) shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. §164.501, limited to the information received by Business Associate from, or on behalf of, Covered Entity.

1.7 Secretary: "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

Section 2: Obligations and Activities of Business Associate Business Associate agrees to the following:

2.1 Not to Use or Disclose PHI Unless Permitted: Business Associate agrees not to use, or further disclose, Protected Health Information other than as permitted or required by the Agreement or as required or allowed by law.

2.2 Use Safeguards: Business Associate agrees to use reasonable safeguards to prevent use or disclosure of the Protected Health Information other than as allowed by this Agreement or as otherwise required or allowed by law.

2.3 Report Inappropriate Disclosure of PHI: Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not permitted by this Agreement or by law.

2.4 Compliance of Agents: Business Associate agrees to require any agents, including subcontractors, to agree to the same restrictions and conditions that apply to Business Associate through this Agreement provided that such agents perform a service that the Business Associate agreed to perform for, or on behalf of, the Covered Entity under the Insurance Policy and, to whom the Business Associate provides Protected Health Information.

2.5 Access: To the extent the Business Associate maintains the original Designated Record Set, Business Associate agrees to provide access to Protected Health Information in the Designated Record Set, during normal business hours, provided the Covered Entity delivers prior written notice to the Business Associate, at least five business days in advance, requesting such access but only to the extent required by 45C.F.R. §164.524. It is the intent of both the Covered Entity and the Business Associate that the Business Associate not maintain the original Designated Record Set.

2.6 Amendments: To the extent the Business Associate maintains the original Designated Record Set, Business Associate agrees to incorporate any amendment(s) to Protected Health Information in the original Designated Record Set that the Covered Entity directs, pursuant to 45 C.F.R. §164.526.

2.7 Disclosure of Practices, Books and Records: Unless otherwise protected from discovery or disclosure by law or unless otherwise prohibited from discovery or disclosure by law, Business Associate agrees to make internal practices, books, and records available to the Covered Entity or to the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule but only to the extent such access is related to the use and disclosure of Protected Health Information received from the Covered Entity, or created or received by Business Associate on behalf of Covered Entity. Business Associate shall have a reasonable time within which to comply with such requests and, in no case shall access be required in less than five business days after the Business Associate's receipt of such request.

2.8 Accounting: Business Associate agrees to maintain sufficient documentation to allow it to provide to Covered Entity a list of any disclosures of Protected Health Information by the Business Associate or its agents so as to allow the Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. §164.528. Business Associate provides the Covered Entity with Services in accordance with Section 3.1 of this agreement which may prohibit Business Associate from disclosure of such accounting.

2.9 Release of Documentation of Disclosures: Business Associate agrees to provide to Covered Entity information collected in accordance with Section 2.9 of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. §164.528. Business Associate shall have a reasonable time within which to comply with such requests and, in no case shall access be required in less than five business days after the Business Associate's receipt of such request.

Section 3: Permitted Uses and Disclosures by Business Associate

3.1 Use of PHI for Specified Purposes: Under the Insurance Policy, the Business Associate provides the Covered Entity with services related to the Insurance Policy, hereinafter "Services" that involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, administering the issuance of professional liability insurance; receiving and evaluating incidents, claims, and lawsuits; quality assessment; quality improvement; loss prevention tools; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of health care practitioners and providers; credentialing, conducting or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance; resolution of internal grievances, and other functions necessary to perform these Services. Except as otherwise specified herein, the Business Associate may make any uses of Protected Health Information necessary to perform its obligations under this Agreement and under the Insurance Policy. Moreover, the Business Associate may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to it employees, subcontractors, and agents, in accordance with paragraphs Section 3.2 through 3.4 of this Section below; or (ii) as otherwise permitted by the terms of this Agreement. All other uses not authorized by this Agreement are prohibited.

3.2 Use of PHI for Business Associate Management and Administration: Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

3.3 Disclosure Required by Law or With Reasonable Assurances: Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate and to carry out it’s legal responsibilities, provided that disclosures are required by law, or provided that the Business Associate obtains the following reasonable assurances from the person or entity to whom the Protected Health Information is disclosed; 1) the PHI will remain confidential; 2) the PHI will be used or further disclosed only as required by law or for the purposes for which it was disclosed; and, 3) the person or entity will notify the Business Associate of any instances of which the person or entity is aware in which the confidentiality of the information has been breached.

3.4 Data Aggregation Services: Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(0(3).

Section 4: Impermissible Requests by Covered Entity

4.1 Business Associate understands that the Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except that, despite this Section 4, Business Associate may use or disclose Protected Health Information for data aggregation or management and administrative activities of Business Associate as is otherwise permitted by this Agreement.

Section 5: Term and Termination
5.1 Term: The Term of this Agreement shall be effective during the term of the Insurance Policy and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section.

5.2 Termination for Cause: Upon Covered Entity's knowledge of a material breach by Business Associate of this Agreement, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. Covered Entity may terminate this Agreement, and Business Associate agrees to such immediate termination, if Business Associate has breached a material term of this Agreement and cure is not possible.

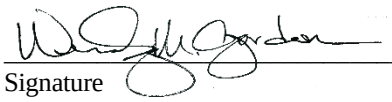
5.3 Effect of Termination: Upon termination of the Insurance Policy, the protections of this Agreement will remain in force and Business Associate shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of its business or to carry out its legal responsibilities or as required by law.

Section 6: Miscellaneous Provisions
6.1 Regulatory References: A reference in this Agreement to a section in the Privacy Rule means the Section in effect or as amended, and for which compliance is required.

6.2 Amendment: The Business Associate agrees to take such action as is necessary to amend this Agreement from time to time as is necessary, as determined by the Business Associate, for compliance with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191 as determined by the Business Associate.

6.3 Survival: The rights and obligations of Business Associate under this Agreement shall survive the termination of this Agreement and the termination of the Insurance Policy.

6.4 Interpretation: Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

Business Associate	Policyholder Representative
Wendy Gordon DM, MPH, CPM	
Print Name	Print Name
	
Signature	Signature
Wendy Gordon Consulting, LLC for the Washington State Joint Underwriting Association as a Third Party Administrator	
Company	Company (If Applicable)
	Date: