SUPPLEMENT FOR NURSE MIDWIFE FOR PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS PROFESSIONAL LIABILITY

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant:

2. Estimated number of births for the next twelve (12) months:

3. Name of supervising M.D. or D.O. and medical specialty:

4. (a) Name of facility where the Applicant practices:

   (b) Is the above facility either JCAHO and/or National Association of Childbirth Centers accredited? [ ] Yes [ ] No

6. Does the Applicant perform any home births? [ ] Yes [ ] No. If Yes, provide details.

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understand that information submitted herein becomes a part of my/our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant (within 60 days of the proposed effective date).

Name of Applicant | Title (Officer, partner, etc.)

Signature of Applicant | Date

AS PART OF THIS SUPPLEMENT ATTACH THE FOLLOWING:

Copy of patient selection and referral Protocol under which the Applicant practices

Copy of current American College of Nurse - Midwives certification