



TEXAS MEDICAL INSURANCE COMPANY

ENCLOSED ARE THE FORMS NECESSARY FOR APPLICATION

- Applicant must be employed and supervised by a TMLT insured physician.**
- Complete and sign the *Application for Coverage*.
- Complete the *Claim/Suit Information Addendum* if a professional liability claim or suit has **ever** been brought against you.
- Copy of certificate or licensure.
- IMPORTANT! Attach a copy of your *Declarations Page* and all other pages relative to the retroactive or prior acts date of your current insurance.**
- If payment is included make your check payable to *Texas Medical Insurance Company* or *TMIC*.
- Return all applicable forms to:
P.O. Box 160140
Austin, TX 78716-0140
We encourage the return of multiple applications for one company in the same envelope.
- Include a listing of all applicants by name and profession.

Instructions regarding premium payment:

Quarterly and annual payment options will be billed by invoice and mailed to the *Named Insured*.

If you choose the monthly payment option, you must complete, sign and return the enclosed *Authorization for Direct Bank Debit* along with a voided check on the account to be debited.

If you have any questions, we will be happy to assist you. Call our toll free number listed below and ask for Sales.

TEXAS MEDICAL INSURANCE COMPANY

P.O. Box 160140 • Austin, TX 78716-0140

901 Mopac Expressway South • Barton Oaks Plaza V, Suite 500 • Austin, TX 78746

Toll free: 800-580-8658 • Local: 512-425-5800 • Fax: 512-425-5998

Email: sales@tmic.biz • www.tmic.biz

Receipt by TMIC of application(s) and/or premium payment does not constitute a binder or acceptance of coverage.



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NURSE-MIDWIFE SUPPLEMENTAL APPLICATION

I. _____
First Name of Applicant Middle Name Last Name Title

2. What is your average patient load per week? _____

3. Which method of natural childbirth do you practice?

4. How many vaginal deliveries do you perform per year? _____
a. Hospital Vaginal #/year _____ VBAC #/year _____
b. Freestanding Birthing Center Vaginal #/year _____ VBAC #/year _____
c. Home Vaginal #/year _____ VBAC #/year _____
d. Other (please describe) _____

5. Do you participate in the performance of c-sections as part of your practice? Yes [] No []

If yes, #/year _____

Please specify in what capacity:

6. Are you associated with a hospital or freestanding birthing center? Yes [] No []

If yes, name:

Name City State

Signature of Applicant

Date Signed