Membership #_____

South Carolina Medical Malpractice
PATIENTS' COMPENSATION FUND
PO Box 210738
Columbia, SC 29221-0738
(803) 896-5290 Fax (803) 896-5294

CERTIFICATE OF MEMBERSHIP
ASSESSABLE

General Information

Name | Date of Birth | License Number

Work Address | Telephone

Home Address | Telephone

Billing Email Address | Fax

Primary Insurance | Primary Policy # | Primary Policy Dates | Primary Limits

Type of Policy (Occurrence or Claims Made) | Primary Ins Premium | Specialty

Are you a U.S. Citizen _____ Yes _____ No. If no, what is your current status: _____
Please notify us of any changes immediately.

Coverage Sought *(Please indicate which type of coverage you are applying for.)*

_____ **Occurrence Coverage**

_____ **Claims-Made Coverage without Prior Acts Coverage**.
(Check the one appropriate response below):

_____ An Extended Reporting Endorsement (tail coverage) is automatic or will be purchased from my current carrier. *Note: if previously insured on a claims-made basis, failure to obtain an Extended Reporting Endorsement will leave you without complete coverage.*

_____ My current policy is on an occurrence form.

_____ **Claims-Made Coverage with Prior Acts Coverage**.
(This is subject to approval by the basic carrier.)

Requested Retroactive Date (MM/DD/YY): _____ 12:01 a.m.
(This date cannot be greater than the retroactive date shown on your current policy.)

PCF Limits

(All limits are inclusive of underlying coverages, which coverages must be a minimum of $200,000 per occurrence/ $600,000 annual aggregate -- please indicate desired limits)

- ❑ $1,000,000 Per Occurrence / $3,000,000 Annual Aggregate _____
- ❑ $1,200,000 Per Occurrence / $3,600,000 Annual Aggregate _____
- ❑ $2,000,000 Per Occurrence / $4,000,000 Annual Aggregate _____
- ❑ $3,000,000 Per Occurrence / $6,000,000 Annual Aggregate _____
- ❑ $5,000,000 Per Occurrence / $7,000,000 Annual Aggregate _____
- ❑ $10,000,000 Per Occurrence / $12,000,000 Annual Aggregate _____

Total Membership Fee _____

- I hereby understand and agree that it is my responsibility to directly contact the PCF regarding any changes to my membership.
- I hereby agree to assist and cooperate with the PCF in all matters connected with my membership in the PCF.
- I understand and agree that my membership in the PCF is contingent on my having in force primary malpractice insurance coverage with limits not less than $200,000 per occurrence and $600,000 annual aggregate for all claims and that the limits listed herein are inclusive of all underlying coverages, unless I have been certified by the PCF as a self-insured.
- I understand and agree that my membership, along with all benefits provided to me by the PCF, will be suspended during the entire period of time that I do not have the required primary malpractice insurance coverage in force, unless I have been certified by the PCF as a self-insured.
- I understand and agree that the PCF has no obligation and will make no payments for the defense or settlement of claims or judgments for occurrences happening under occurrence based policies or claims brought under claims-made policies during any suspension period.
- I understand and agree that PCF membership shall not become effective until the PCF receives this certificate and payment of all fees and assessments, if any, and the primary policy is in effect, as evidenced by a copy of my primary Declarations Page.
- I understand and agree that the withdrawal of my membership in the PCF requires thirty days written notice prior to the date of withdrawal; and that I remain subject to any assessment pertaining to any year in which I participated in the PCF.

- I understand and agree that my coverage with the PCF ends when the annual aggregate limit is exhausted and I will be personally and financially responsible for any additional claim amounts within that membership year.

- I understand and agree that, unless previously authorized, the claims-made coverage does not cover me for any claims which occurred prior to the retroactive date if claims-made coverage is chosen.

By signing this Application for Membership in the Patients' Compensation Fund, the Named Member represents and warrants that the statements in the Application, and any subsequent notice relating to the subject of the membership agreement, are true and complete and a material part of the Certificate of Membership. The Named Member acknowledges that this Application together with the Certificate of Membership issued by the Patients' Compensation Fund will continue in force in reliance upon the truth of these representations and warranties. This Application together with the Certificate of Membership embodies all of the agreements between the Named Member and the South Carolina Patients' Compensation Fund.

Member _____ Date _____

Broker Information *(Broker must sign this application)*

I certify that I am duly licensed by an insurer authorized in South Carolina to write liability insurance other than automobile. I certify that I have reviewed this application.

_____ _____

Signature of Broker Date

Broker Name: _____ Contact Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Fax: _____ Email: _____

PCF Use Only

The PCF membership of _____

is hereby certified effective _____ expiration _____.

Said membership is subject to the aforementioned conditions.

Date_____ Administrator _____

Please return this form and a copy of your primary declarations page to the PCF at the above address. A copy will be sent to you after processing.