Membership #_____

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

HOSPITAL & CLINIC
CERTIFICATE OF MEMBERSHIP
New Member____ Renewal____
ASSESSABLE

Section I – General Information

_____
Organization Name

_____
Address Telephone

_____
Fax Number E-Mail Address

License# _____ Type of License _____ Date Issued _____

Applicant is: ____ For Profit ____ Non Profit ____ Governmental ____ Free Clinic

Type of Facility: _____ Hospital _____ Clinic _____ Mental or Psychopathic Institution
_____ Surgical Center _____ Blood Bank
_____ Other – Please describe: _____

Section II – Insurance Information

Name of Current Underlying Insurance Carrier _____

Policy # _____ Effective/Expiration Date _____

Basic Limits _____ Premium _____

Type of Policy: _____ Occurrence _____ Claims-Made Retroactive Date _____

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.)

Section III – Rating Information

No. of Outpatient Visits _____ No. of Outpatient Surgeries_____
(Outpatient visits means the total number of visits made by patients who did not receive bed and board service. This includes emergency room treatments.)

No. of Beds _____ *(Beds means total number of beds, cribs, and bassinets used for patients.)*

Average No. Occupied Beds _____ *(Average number occupied is the sum of the daily number of beds, cribs and bassinets used for patients during the preceding 12 months divided by 365.)*

Do you wish to include employees as additional insureds? Yes / No (please circle)
(Employee coverage includes administrative staff.)

This endorsement provides coverage for these employees while acting within the scope of their duties as such. If you elect coverage for these employees, the Organization also agrees to pay all sums it is obligated vicariously to pay as damages because of any claim or claims made against the organization arising out of an occurrence which is caused by an employee during the policy period. This endorsement may not be used to extend individual coverage to additional physicians, other than those listed on the first page of this certificate, or to dentists, pharmacists, chiropractors, podiatrists, nurse anesthetists, physician assistants, anesthesia assistants, nurse practitioners, nurse midwives, perfusionists or surgical technicians. ***These providers must have their own individual coverage.***

Please provide on a separate sheet a list of all Professional Employees and their specialty to be covered under the vicarious liability coverage.

Free Medical Clinic – No. of Volunteer Physicians Slots _____ No. of Volunteer Dentists Slots _____ Other Professional Volunteers

Section IV – 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).

PCF Membership Fee

- ❑ $1,000,000 Per Occurrence / $3,000,000 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 _____

(If the basic limit is $1,000,000 per occurrence/$3,000,000 annual aggregate the optional limit of $1,000,000 per occurrence/$3,000,000 annual aggregate is not available.)

- 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 the suspension period.

- I understand and agree that PCF membership shall not become effective until the PCF receives both this certificate and payment of all fees and assessments, if any, and the primary policy is in effect.

- I understand and agree that the withdrawal of my membership in the PCF requires written notice of thirty days 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 if lower limits of coverage are chosen my coverage with the PCF ends when the annual aggregate limit is exhausted and the hospital or clinic 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 _____

Print Name _____

Broker <u>must</u> 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: _____

If you are a new PCF member please include a 10-year loss history and prior basic insurance information with this application.

(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 above address, a copy will be sent to you after processing.