Membership #_____

**SC Medical Malpractice Patients' Compensation Fund**
**Application for Membership Agreement**
**PO Box 210738 - Columbia, SC 29221-0738**
**Tel# (803) 896-5290 Fax# (803) 896-5294**

# CERTIFICATE OF MEMBERSHIP FOR NON-JUA MEMBERS EXCESS PROFESSIONAL LIABILITY INSURANCE
## ASSESSABLE

## General Information

Name | Name of Group Practice | SC License No.

Work Address | Telephone

Home Address | Telephone

E-mail Address | Fax

Date of Birth _____ Requested Effective Date _____

Is 100% of your practice generated in South Carolina? ____ Yes ___ No If no, please explain: _____

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

## Insurance Information

Name of Current Primary Insurance Carrier _____

Policy # _____ Effective/Expiration Dates _____

Basic Limits _____ Premium _____

Type of Policy ___ Occurrence ___ Claims Made Retroactive Date if Claims Made: _____

Name of Additional Underlying Insurance Carrier (if applicable)_____

Policy # _____ Effective/Expiration Dates _____

Basic Limits _____ Premium _____

Type of Policy ___ Occurrence ___ Claims Made Retroactive Date if Claims Made: _____

**PLEASE ATTACH A COPY OF THE DECLARATION PAGE(S) FROM YOUR CURRENT BASIC AND/OR EXCESS INSURANCE POLICY WHICH PROVIDES THE POLICY NO., POLICY PERIOD, LIMITS AND INDICATE WHETHER IT IS A CLAIMS MADE OR AN OCCURRENCE POLICY.**

**IN ADDITION, IF YOUR PRIOR COVERAGE *WAS NOT* OBTAINED THROUGH THE SOUTH CAROLINA JUA AND PCF, WE REQUIRE A 10-YEAR LOSS HISTORY FROM YOUR PRIOR INSURANCE CARRIER(S), AND A REPORT FROM THE NATIONAL PRACTITIONER DATA BANK. You may contact the NPDB by dialing 1-800-767-6732 or logging on to their website: www.npdb-hipdb.com.**

| POL# | INS. COMPANY | POLICY PERIOD | LIMITS | CLAIMS MADE/OCCURENCE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## Preceptor Information

Preceptor's Name _____ Preceptor's Membership #_____ Preceptor's Specialty _____

Name of practice/entity organization: _____

Check if you are a:

_____ Registered Nurse _____ Nurse Practitioner _____ Nurse Anesthetist _____ Nurse Midwife
_____ Pharmacist _____ Physician Assistant _____ Surgical Technician _____ Anesthesia Assistant

Have you ever failed any licensing or Board Certification or recertification examination: ____ Yes ____ No.

Do you assist in Major Surgery ____ Yes _____ No If yes, _____ on own patients only _____ on patients of others.

If yes, please describe what types of major surgery: _____

*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.)

## Classification of Applicant

Primary Specialty _____ Please describe any Moonlighting Activities _____

Please check all categories that apply:

___ No surgical procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia.

____ Circumcisions ____ D&C performed under local anesthesia. ____ Liver or Kidney Biopsy
____ Acupuncture ____ Arterial, Intravenous, Cardiac, or Diagnostic ____ Catheterizations

____ Vasectomies ____ Sedation Analgesia or Conscious Sedation ____ Bone Marrow Biopsy
____ Liposuction ____ Endoscopy, Colonoscopy or EGD ____ Plastic/Cosmetic Procedures
____ Obstetrical Procedures ____ Deliveries ____ Cesarean Sections ____ Prenatal after 1st Trimester
___ Other types of Surgery and Operations performed under General Anesthesia. Please describe:
_____

Please answer YES or NO. If your answer is YES to any of the following questions, indicate the date(s) and state(s) (if applicable) where action occurred. Please provide full details on a separate page.

1. Have you had a denial, restriction, suspension, probation, or revocation of privileges by a hospital or other health care facility? _____ Yes ____ No Date _____ State _____

2. Have you entered into any consent agreement related to your privileges with any formal committee of a hospital or other health care facility? _____ Yes ____ No Date _____ State _____

3. Have you had a denial, restriction, suspension, probation, or revocation of your privileges to prescribe medications by the Drug Enforcement Administration? _____ Yes ____ No Date _____ State _____

4. Have you had a denial, restriction, suspension, probation, or revocation of your license to practice medicine by any State Licensing Board or been issued a public reprimand? _____ Yes ____ No Date _____ State _____

5. Have you entered into a consent agreement related to your license with any State Licensing Board or any other medical review committee in your field of practice? _____ Yes _____ No Date _____ State _____

6. Have you been convicted of or pled guilty to any misdemeanor or Driving Under the Influence (excluding minor traffic violations)? _____ Yes ____ No Date _____ State _____

7. Do you prescribe or administer substances that are not FDA approved, perform procedures that are considered experimental, or perform procedures for which you do not have appropriate training or are not board certified? _____ Yes ____ No

8. Have you had an injury, illness, or other event occur that may impair your ability to practice? _____ Yes ____ No Date _____

9. Have you been declined, non-renewed, or cancelled by an insurance carrier with cause (excluding market withdrawal)? _____ Yes ____ No Date _____ Insurance Carrier _____

10. Have you experienced a medical incident or alleged injury in which there is no reasonable defense and failed to report it to your insurance carrier within 30 days of the occurrence? _____ Yes ____ No
Date of incident/alleged injury _____
Date reported _____ Insurance carrier _____

11. Have you been found by a court of law or State Licensing Board to have participated in any sexual misconduct with a patient? _____ Yes ____ No Date _____ State _____

12. Have you been convicted of or pled guilty to a felony or have you been convicted of or pled guilty to a criminal offense for which one of the elements is fraud or misrepresentation? _____ Yes ____ No Date _____ State _____

13. Have you been accused of or been found to have altered health care records? ___ Yes ___ No Date _____

## PCF Limits

***(The four limits listed immediately below are inclusive of underlying coverage, which 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 _____

If you have basic limits of $1,000,000/$3,000,000 the following excess limits are available:

- ❑ $1,000,000 Per Occurrence / $3,000,000 Annual Aggregate _____
- ❑ $2,000,000 Per Occurrence / $3,000,000 Annual Aggregate _____
- ❑ $4,000,000 Per Occurrence / $4,000,000 Annual Aggregate _____
- ❑ $9,000,000 Per Occurrence / $9,000,000 Annual Aggregate _____

***( This coverage is in addition to, not inclusive of, your basic limits.)***

If you have basic limits of $3,000,000/$6,000,000 the following excess limits are available:

- ❑ $2,000,000 Per Occurrence / $1,000,000 Annual Aggregate _____
- ❑ $7,000,000 Per Occurrence / $6,000,000 Annual Aggregate _____

***( This coverage is in addition to, not inclusive of, your basic limits.)***

If you have basic limits of $5,000,000/$7,000,000 the following excess limit is available:

- ❑ $5,000,000 Per Occurrence / $5,000,000 Annual Aggregate _____

***( This coverage is in addition to, not inclusive of, your basic limits.)***

**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, with the exception of the optional excess limits, 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.

**FIRST YEAR RISK MANAGEMENT DISCOUNT** _____ (Initial here if applicable)

I am beginning my first year of practice since the completion of my medical training, and I agree to qualify for a 25% first year premium reduction subject to a maximum $2,000 premium reduction by completing the South Carolina Medical Association's Risk Management Program during my first year of practice. This discount is in the form of an endorsement with a return premium credit issued upon receipt of SCMA certificate of completion for the Risk Management program.

*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.*

_____ _____

Signature of Applicant 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

The information contained in this Membership Application is privileged and confidential. It is intended only for the use of the Patients' Compensation Fund. If the reader of this Application is not the intended recipient, you are hereby notified that any dissemination, distribution, or copy of this Application is strictly prohibited. If you have received this Application in error, please notify us immediately by telephone and return the original Application to us via the U.S. Postal Service. Thank you.

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.**