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

Membership # _____

PROFESSIONAL LIABILITY SUPPLEMENTAL APPLICATION FOR PART TIME CREDIT

Healthcare Providers

The PCF will permit a discount for the following part time members:

- Retired non-practicing PCF members donating time to charitable or non-profit organizations
- Emergency medicine residents moonlighting at rural or small community emergency room departments
- Part time and/or semi-retired PCF members who are working no more than eighty-five hours per month
- Healthcare providers who are employed by a hospital or other facility requesting coverage for outside activity

Conditions

- A Part Time Professional Liability Application must be completed by the applicant every year for the purposes of determining whether the applicant is eligible for this type of coverage.
- The hours reported to the PCF for rating purposes are subject to audit, at the PCF's discretion.
- No other credits apply concurrent with this rule except for Risk Management Discounts.
- Members who are subject to experience rating and schedule rating surcharges are not eligible for this part time discount.

Personal Data for Applicant

Name: _____ Primary Policy # _____

Office Address: _____

Telephone No _____ Billing Email: _____

Name of Employer or Professional Affiliation: _____

Do you have medical malpractice insurance through any other carrier? _____Yes _____No

If yes, provide the name of the insurance Carrier _____

Policy # _____ Effective/Expiration Dates __/___ /____ Basic Limits _____ Premium _____

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

List Hospitals which you currently hold privileges at: _____

Number of hours worked per month: _____ Effective Date: _____

Name and telephone number of individual that PCF may contact for audit of records: _____

By signing this Application for Membership in the Patients' Compensation Fund, the Applicant 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 Applicant 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 Applicant and the South Carolina Patients' Compensation Fund.

_____ _____
Signature of Applicant Date