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 FOR A PROFESSIONAL ASSOCIATION
ASSESSABLE

General Information

_____
Association Name

_____
Address Telephone

_____
E-mail Address Fax

_____
Primary Insurance Primary Policy # Primary Policy Dates

_____
Type of Policy (Occurrence or Claims Made) Primary Ins Premium Primary Limits

Please list below the names of all employed physicians or member physicians of the Professional Association. You must check whether the participant is an employed physician (an individual who does not have ownership interest in the PA), or a member physician (an individual who does have ownership interest in the PA). NOTE: contracting physicians are considered to be employed physicians.

PHYSICIAN NAME	SPECIALTY	EMPLOYED	MEMBER
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

Other Professional Employees

An employer may incur a legal responsibility for the actions of his/her employee(s). Additional charges shall be made based on the number and type of employee(s) to reflect this exposure. This additional charge does not indicate that coverage is being provided to the employee(s), but only contemplates coverage for liability that may be imputed to the employer. Do you employ any of the following?

1. Radiation Therapy - Employed Physician or Surgeon ____Yes ____ No How Many? _____
2. Shock Therapy – Employed Physician or Surgeon ____Yes ____ No How Many? _____
3. Employed Technician – Radiation Therapy ____Yes ____ No How Many? _____
4. Employed Technician – X-ray or Pathological ____Yes ____ No How Many? _____
5. Employed Physician Assistant ____Yes ____ No How Many? _____
6. Employed Nurse Practitioner ____Yes ____ No How Many? _____
7. Employed Nurse Midwife ____Yes ____ No How Many? _____
8. Employed Anesthesiologist ____Yes ____ No How Many? _____
9. Employed Nurse Anesthetist ____Yes ____ No How Many? _____
10. Employed Licensed Therapist ____Yes ____ No How Many? _____
11. Employed Licensed Estheticians ____Yes ____ No How Many? _____
12. Other (Please specify) _____

If you answered yes to 5, 6, 7, 8 or 9 please provide the name of their basic carrier, policy number and limits of coverage.

_____

_____

_____

(Please notify us of any changes immediately.)

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

This endorsement provides coverage for the actions of your employees while they are acting within the scope of their duties as such. If you elect coverage for these employees, the PCF also agrees to cover amounts you are obligated vicariously to pay as damages for an occurrence(s) happening under occurrence based policies or a claim(s) brought under claims-made policies which is caused by your 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.***

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

(Limit is inclusive of underlying coverage, which must be a minimum of $200,000 per occurrence / $600,000 annual aggregate.)

$1,000,000 Per Occurrence / $3,000,000 Annual Aggregate
(Effective 6/1/05 only limits of $1,000,000 / $3,000,000 are available to corporations.)

(Membership fees are subject to change after verification of information regarding members and employees of the Professional Association.)

- The Professional Association hereby understands and agrees that it is the Professional Association's responsibility to directly contact the PCF regarding any changes to its membership.

- The Professional Association hereby agrees to assist and cooperate with the PCF in all matters connected with its membership in the PCF.

- The Professional Association understands and agrees that its membership in the PCF is contingent on its 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 the Professional Association has been certified by the PCF as a self-insured.

- The Professional Association understands and agrees that its membership, along with all benefits provided to it by the PCF, will be suspended during the entire period of time that the Professional Association does not have the required primary malpractice insurance coverage in force, unless the Professional Association has been certified by the PCF as a self-insured.

- The Professional Association understands and agrees 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.

- The Professional Association understands and agrees 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 the Professional Association's primary Declarations Page.

- The Professional Association understands and agrees that the withdrawal of its membership in the PCF requires thirty-day's written notice prior to the date of withdrawal; and that the Professional Association remains subject to any assessment pertaining to any year in which it participated in the PCF.

- The Professional Association understands and agrees that its coverage with the PCF ends when the annual aggregate limit is exhausted and the Professional Association will be

personally and financially responsible for any additional claim amounts within that membership year.

- The Professional Association understands and agrees that, unless previously authorized, the claims-made coverage does not cover it 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 Professional Association 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 Professional Association 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 Professional Association and the South Carolina Patients' Compensation Fund.

Signature on behalf of
Professional Association _____ Date _____

Print Name _____ Position _____

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 the Professional Association's primary declarations page to the PCF at the above address. A copy will be sent to you after processing.