Membership #_____

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

DENTAL & ORAL SURGEON PROFESSIONAL ASSOCIATION CERTIFICATE OF MEMBERSHIP

ASSESSABLE

_____
Association Name

_____
Address Telephone

Fax Number _____ E-Mail Address _____

_____
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 dentists or member dentists of the Professional Association. Determine the appropriate class for the dentists by using the attached addendum on page 3. You must check whether the participant is an employed dentist (an individual who does not have ownership interest in the PA), or a member dentist (an individual who does have ownership interest in the PA). NOTE: contracting dentists are considered to be employed dentists.

NAME	CLASS	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 for the employee(s) to reflect this exposure. The additional charge does not indicate that coverage will be provided to the employee(s), but only contemplates coverage for liability that may be imputed to the employer.

Do you wish to include employees as additional insureds? Yes / No (please circle)
(Employee coverage includes hygienists, dental assistants, surgical technicians, and 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 Association also agrees to pay on your behalf all sums you shall be obligated vicariously to pay as damages because of any claim or claims made against you arising out of an occurrence 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.***

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.)*

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.)

- 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 judgment for incidents, which occur 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 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.

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

CLASS DETERMINATION ADDENDUM

CLASS	PROCEDURE/SPECIALTY	ANESTHESIA
Class 1	General Dentistry Endodontics Pedodontics Prosthodontics Orthodontics Periodontics / Non-Osseous Surgery, Non-Advanced or Non Refractory Progressive Periodontitis Implant Prostheses / Non Surgical Removal of Impacted Wisdom Teeth Soft Tissue Only	In the office: Local Nitrous Oxide Oral Conscious IV Administered in the hospital by other than an insured or insured's employee: General Deep Intra Muscular (I.M.)
Class 2	Periodontics/Osseous Surgery, Advanced or Refractory Progressive Periodontitis Implant Prostheses / Non Surgical Removal of Impacted Wisdom Teeth Other than Soft Tissue	Conscious I.M. in the office
Class 2A	Implants / Surgical	
Class 3	Oral Surgeon Maxillofacial Surgery	General Anesthesia and/or Deep Sedation given in a dosage to render the patient unconscious and done in the office; or in a hospital if administered by an insured or insured's employee.

Please determine the appropriate class for each dentist and specify your selection on page 1 of this Certificate of Membership next to the dentist's name.

Any procedure or anesthesia in a higher class would make the higher class applicable.

This completed Certificate of Membership must be returned in order to process and renew the membership of your Professional Association with the PCF.