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 HOSPITAL & CLINIC

New Member____ Renewal____

ASSESSABLE

General Information

_____
Organization Name

_____
Address Telephone

_____
E-mail Address Fax

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: _____

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.)

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 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 the Organization is 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 an employee during the policy period. This endorsement may not be used to extend individual coverage to individual physicians, 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

PCF Limits

(All limits 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 _____
- ❑ $2,000,000 Per Occurrence / $4,000,000 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.)

- The Organization hereby understands and agrees that it is the Organization's responsibility to directly contact the PCF regarding any changes to its membership.
- The Organization hereby agrees to assist and cooperate with the PCF in all matters connected with its membership in the PCF.
- The Organization 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.
- I understand and agree that the limits listed herein are inclusive of all underlying coverages, unless the Organization has been certified by the PCF as a self-insured.
- The Organization 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 Organization does not have the required primary malpractice insurance coverage in force, unless the Organization has been certified by the PCF as a self-insured.
- The Organization understands and agrees that the PCF has no obligation and will make no payments for claims or judgments for occurrences happening under occurrence based policies or claims brought under claims-made policies during any suspension period.
- The Organization 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 Organization's primary Declarations Page.

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

- The Organization understands and agree that its coverage with the PCF ends when the annual aggregate limit is exhausted and the Organization will be personally and financially responsible for any additional claim amounts within that membership year.

- The Organization 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 Organization 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 Organization 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 Organization and the South Carolina Patients' Compensation Fund.

Signature on behalf of
Organization _____ 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: _____

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.