



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 PRIVATE CARRIERS
 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.

A.

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 _____

B.

1. 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 _____
2. 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 _____
3. Have you been convicted of or pled guilty to any misdemeanor or Driving Under the Influence (excluding minor traffic violations)? Yes No Date _____ State _____
4. 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
5. Have you had an injury, illness, or other event occur that may impair your ability to practice? Yes No Date _____
6. Have you been declined, non-renewed, or cancelled by an insurance carrier with cause (excluding market withdrawal)? Yes No Date _____ Insurance Carrier _____
7. 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 _____

C.

1. 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 _____
2. 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 _____
3. Have you been accused of or been found to have altered health care records? Yes No Date _____

PCF Limits

(The five 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 |
|--|---------------------------|
| <input type="checkbox"/> \$1,000,000 Per Occurrence / \$3,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$2,000,000 Per Occurrence / \$4,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$3,000,000 Per Occurrence / \$6,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$5,000,000 Per Occurrence / \$7,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$10,000,000 Per Occurrence / \$12,000,000 Annual Aggregate | _____ |

If you have basic limits of \$1,000,000/\$3,000,000 there are optional limits of excess available.
(This coverage is in addition to, not inclusive of, your basic limits.)

- | | |
|--|-------|
| <input type="checkbox"/> \$1,000,000 Per Occurrence / \$1,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$1,000,000 Per Occurrence / \$3,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$2,000,000 Per Occurrence / \$3,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$4,000,000 Per Occurrence / \$4,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$9,000,000 Per Occurrence / \$9,000,000 Annual Aggregate | _____ |

If you have basic limits of \$2,000,000/\$4,000,000 there are optional limits of excess available.
(This coverage is in addition to, not inclusive of, your basic limits.)

- | | |
|--|-------|
| <input type="checkbox"/> \$1,000,000 Per Occurrence / \$2,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$3,000,000 Per Occurrence / \$3,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$8,000,000 Per Occurrence / \$8,000,000 Annual Aggregate | _____ |

If you have basic limits of \$3,000,000/\$6,000,000 there are optional limits of excess available.
(This coverage is in addition to, not inclusive of, your basic limits.)

- | | |
|--|-------|
| <input type="checkbox"/> \$2,000,000 Per Occurrence / \$1,000,000 Annual Aggregate | _____ |
| <input type="checkbox"/> \$7,000,000 Per Occurrence / \$6,000,000 Annual Aggregate | _____ |

If you have basic limits of \$5,000,000/\$5,000,000 there is an optional limit of excess available.
(This coverage is in addition to, not inclusive of, your basic limits.)

- | | |
|--|-------|
| <input type="checkbox"/> \$5,000,000 Per Occurrence / \$7,000,000 Annual Aggregate | _____ |
|--|-------|

Total Membership Fee _____

PCF Agreement

- 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.
- I understand and agree 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.