

***Professional Association, Partnership or Corporate
Professional Liability Insurance Application***

South Carolina Medical Malpractice Liability Insurance
Joint Underwriting Association
Assessable Policy



**For assistance, please contact Marsh, the Program Administrator, at:
864-240-5400**

**SCJUA
c/o Marsh USA Inc.
550 South Main Street, Suite 600
P. O. Box 128 (29602)
Greenville, SC 29601
Fax: 864-240-2750**

Return Completed Application to:

Broker Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax: _____

Contact Name: _____

E-mail: _____

Important: No action can be taken on this application until it is fully completed. "Fully completed" means you have answered all questions, provided separate explanations where necessary, signed and dated in the appropriate places, and attached the following documents:

New Business or Rewrite:

1. Copy of current declarations page showing type of policy form and current retroactive date; and,
2. Verification of or intent to obtain Reporting Coverage (tail) from current carrier; and,
3. Loss run from all previous Professional Liability insurers for not less than the prior 10 years, or since you first became licensed, whichever is greater. The evaluation or date of issue of such loss runs may not be more than sixty (60) days old; and, a National Practitioner Databank report. (www.npdb-hipdb-hrsa.gov or 1-800-767-6732)
4. Copy of business letterhead.
5. **Coverage is not bound until the JUA receives payment in full.**

For JUA Use Only	Rating Class		Other Charges		Policy Fee	
	Endorsements				Final Premium	

SECTION I - PRACTICE LOCATION AND GENERAL INFORMATION

Name of Applicant/Entity: _____

Corporate Tax ID Number: _____

Preferred **Billing** Address: (List other locations on page 7 of this application.)

Number & Street _____ Suite _____ County _____

City _____ State _____ Zip _____

(_____) Office Telephone Number (_____) Office Fax Number

Contact Name: _____ E-mail Address: _____

May we contact you by e-mail: Yes No

SECTION II - COVERAGE SELECTION INFORMATION

Important Note: SCJUA offers limits of liability of \$200,000 each Medical incident / \$600,000 annual aggregate. For additional coverage, please contact the SC Patients' Compensation Fund at 803-896-5290 or www.spcpf.com

New Policy Re-write Renewal Prior Policy #: _____

A. Type:

- 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 restrictions.)

Requested retroactive date (M/D/Y): _____ 12:01 a.m.
(This date cannot be greater than the retroactive date shown on your current policy.)

B. Effective Date: Requested Coverage Effective Date: (M/D/Y): _____ 12:01 a.m.
(This date cannot be earlier than the expiration date of your current policy. Annual policy terms will begin and end on the same month and day.)

C. Expiration Date: _____

SECTION III - RATING INFORMATION

A. Please list all Physicians or Dentists who are partners/members or officers of the applicant. (Individuals who have an ownership interest in the practice.) **This section must be completed.**

Name	Specialty	Policy #	Insurer

Use page 7 if additional space is needed.

B. Please list all Physicians or Dentists who are employees/independent contractors of the applicant. (Individuals who do not have an ownership interest in this practice.)

Name	Specialty	Policy #	Insurer

Use page 7 if additional space is needed.

C. COMPLETE THIS SECTION ONLY IF YOU ARE THE EMPLOYER.

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 contemplate that coverage will be provided to the employee(s), but only contemplates liability imparted to the employer. Do you employ any of the following?

- | | | | |
|--|------------------------------|-----------------------------|-----------------|
| 1. Radiation Therapy - Employed Physician or Surgeon | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 2. Shock Therapy – Employed Physician or Surgeon | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 3. Employed Technician – Radiation Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 4. Employed Technician – X-Ray or Pathological | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 5. Employed Surgical Technician | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 6. Employed Physician Assistant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 7. Employed Nurse Midwife | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 8. Employed Nurse Practitioner | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 9. Employed Anesthesiologist | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 10. Employed Nurse Anesthetist | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 11. Employed Licensed Therapist | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 12. Employed Licensed Estheticians | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 13. Other (please specify): _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |

If yes to #5, 6, 7, 8, 9, 10, 11 or 12 provide their names and their policy numbers

D. ADDITIONAL INSURED ENDORSEMENT: "STAFF COVERAGE ENDORSEMENT" and VICARIOUS LIABILITY. BROKERS/AGENTS – Please review this carefully with your insured.

Do you wish to include your other employees as additional insureds? (Staff Coverage Endorsement includes RNs, LPNs, medical assistants, lab techs, X-ray techs; hygienist, dental assistants, and administrative staff) Yes No

*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 a medical incident which is caused by your employee during the policy period. This endorsement may not be used to extend individual coverage to *physicians, dentists, pharmacist, chiropractors, podiatrists, nurse anesthetists, physician assistants, anesthesia assistants, nurse practitioners, nurse midwives, perfusionists, or surgical techs. *These providers must have their own individual coverage.*

SECTION IV - ORGANIZATION INFORMATION

A. Please check the boxes below that best describe your practice affiliation(s):

Entity Type

- Professional Association
- Multi-Shareholder Corporation, Partnership, LLC
- Solo Incorporated – No employed or contracted physicians
- Hospital Owned
- Government Owned
- Industrial
- Other: _____

B. Is the purpose of the entity other than a medical or dental office practice? Yes No
If yes, please explain in the Additional Information Section.

C. Do you have any office or expense sharing arrangements with any other physician (s) or practice group(s)? Yes No
If yes, please explain in the Additional Information Section.

D. Do you own or operate a surgery center, facility, laboratory or other outpatient facility? Yes No
If yes, do you have coverage under a separate policy for this exposure? Yes No
If yes, please explain in the Additional Information Section.

E. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes No
If yes, do you have coverage under a separate policy for this exposure? Yes No
If yes, please explain in the Additional Information Section.

F. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? Yes No
If yes, do you have coverage under a separate policy for this exposure? Yes No
If yes, please explain in the Additional Information Section.

G. Has any insurance company (including Lloyds of London) ever cancelled, rescinded, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes No
If yes, please explain in the Additional Information Section.

H. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees or has your ability to participate been revoked, suspended, placed on probation or voluntarily surrendered? Yes No
If yes, please explain in the Additional Information Section.

SECTION V - PROFESSIONAL LIABILITY INSURANCE HISTORY INFORMATION

- A. Have you ever practiced without professional liability coverage? Yes No
- B. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage (tail coverage)? NA Yes No
- C. Have you ever had your request for coverage denied, your policy cancelled or non-renewed or had a policy issued to you that contained restrictions or special exclusions? Yes No

If questions A–C are answered “Yes”, please provide a detailed description in *Additional Comments Section* or on a separate sheet.

- D. If prior carrier was not the SC JUA, please provide information on your Professional Liability Insurance carrier for the previous five years.

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date					
Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Rating Classification					

SECTION VI - IONAY SKIP THIS SE

IF THIS IS A RENEWAL APPLICATION, YOU MAY SKIP THIS SECTION.

Important information regarding questions in Section VI A and B

- The word "claim" and “circumstance” as used in Questions A and B following refer to:
 - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any professional corporation or partnership; or
 - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any professional corporation or partnership including by not limited to: a letter from an attorney or a patient requesting medical records or expressing dissatisfaction regarding your medical treatment, or intent to pursue a claim or file a lawsuit against you, a patient or family member’s dissatisfaction with the outcome of a procedure, treatment, or diagnosis. and/or any other circumstances that might reasonably lead to a claim or suit.
- Please complete the attached *Malpractice Claims History Explanation Form* for each case reported in A 3.

- A. Are you now or have you ever been involved in a malpractice claim or suit, either directly or indirectly? Yes No

If “Yes”, please indicate number of cases below:

Where (County and State)

1. Current number open: _____
2. Current number closed: _____
3. Total number of cases: _____ (1 +2) _____

If “Yes” have all been reported to your current or prior professional liability insurer? NA Yes No

- B. Other than the claims/suits indicated in question A above, are you aware of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge

of any alleged injury arising out of the rendering or failure to render professional service which may give rise to a claim even if you believe the claim or suit would be without merit? Yes No

If "Yes", how many? _____ Please attach details of each circumstance.

If "Yes" have all been reported to your current or prior professional liability insurer? NA Yes No

If all have **not** been reported to your current or prior professional liability insurer please explain in Additional Comments Section or on separate sheet.

- C. Have you ever had an adverse outcome that may have resulted in the following:
- any neurological, sensory, or systemic deficits to a patient (such as brain damage, permanent paralysis, loss of sight or hearing, etc.) Yes No
 - limitations on a patient's activities of daily living Yes No
 - the death of a patient. Yes No

SECTION VII - IONAY SKIP THIS SE HISTORY EXPLANATION FORM

IF THIS IS A RENEWAL APPLICATION, YOU MAY SKIP THIS SECTION.

Malpractice Claims History Explanation

Please complete one for EACH such case, potential claims, or suit reported in Section XII - A and B. Please photocopy this form. All questions must be answered or marked not applicable (NA).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Carrier: _____ File Number: # _____ Telephone #: _____

Address of Insurance Carrier: _____

Date Reported to Insurance Company: _____ Date of incident, treatment and or surgery: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No
What is the status of this matter? Open Closed If "closed" was matter closed with your consent? NA Yes No

(Check applicable description below)

- | | | |
|---|---|---|
| <input type="checkbox"/> Incident report only | <input type="checkbox"/> Suit threatened, no action taken | <input type="checkbox"/> Suit filed but dropped by claimant |
| <input type="checkbox"/> Summary judgment in your favor | <input type="checkbox"/> Jury verdict in your favor | <input type="checkbox"/> Jury verdict in favor of the plaintiff |
| <input type="checkbox"/> Suit settled out of court | <input type="checkbox"/> Suit filed awaiting mediation | <input type="checkbox"/> Suit filed awaiting court action |

If closed, amount of total loss payment paid on your behalf: \$ _____ Date paid: _____

If open, amount of case value (loss reserve) established by carrier: \$ _____

SECTION VIII - IONAY SKIP THIS SES SECTION

<u>Section</u>	<u>Question</u>	<u>Explanation/Comments</u>
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____

SECTION IX - AGREEMENT AND AUTHORIZATION

A. I hereby represent that I have no knowledge of any professional liability suit or stated demand for damages which has been asserted against me, or of any occurrence or circumstance likely to result in such a suit or demand for damages, except as described herein. _____ Initial here

B. It is important to understand the difference between Occurrence Coverage and Claims-made coverage.

1. **Occurrence Coverage:**

I understand that occurrence coverage will respond to incidents that occur during the policy period without any consideration for the date a claim is filed with the insurance company. _____ Initial here

2. **Claims-Made Coverage:**

I understand that claims-made coverage will respond to incidents that take place on or after the prior acts date (“retroactive date”) of the policy and which are reported to the insurance company during the policy period. Claims-made coverage involves a step process with the premium increases over the first five years of coverage following the retroactive date in increments proportional to the claims reporting for that experience. The initial premium and subsequent years’ premium are lower than an occurrence policy. However, as of the fifth year the claims made premium reaches a mature level and premium adjustments are based on annual rate changes only. If coverage is discontinued, a Reporting Endorsement (“Tail Coverage”) must be purchased to provide coverage for claims which have occurred but are not yet reported. _____ Initial here

C. **Signing this application does not bind the JUA to complete the insurance but it is agreed that I hereby warrant that the information contained in this application is accurate and complete to the best of my knowledge. I understand that this application shall be considered a part of the terms and conditions of my policy with the South Carolina Medical Malpractice Liability Insurance Joint Underwriting Association and that my JUA Policy is issued in reliance upon the truth of such representations and that my policy and my application therefore embody all agreements existing between myself and the JUA or any of its brokers relating to this insurance.** _____ Initial here

Date _____

Signature of Applicant _____
(Authorized Representative)

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.

Date _____

Signature of Broker _____

The information contained in this application is privileged and confidential. It is intended only for the use of the JUA. If the reader of this message 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 message to us via the U.S. Postal Service. Thank you.