

South Carolina Medical Malpractice Association
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864.240.5449 *main* **864.240.2750** *fax*
www.scmma.net

ADDITIONAL INSURED – VICARIOUS LIABILITY ENDORSEMENT REQUEST FORM

Instructions:

1. Please read Section "A" carefully, and call the MMA if you have questions.
2. Please answer ALL questions, leaving no blanks.
3. The Endorsement Request form must be signed and dated by the Insured and the Authorized Representative of the Healthcare Facility/Entity.
4. Please scan/email the completed form to the SCMMA Underwriting Department. admin.scmma@marsh.com

TO:

admin.scmma@marsh.com

Attn:

FROM:

_____ Date: ____ / ____ / ____
Insured or Authorized Representative of Insured (Printed)

Phone: _____

Email: _____

Total # of Pages: _____

The information contained on this form is privileged and confidential. It is intended only for the use of the MMA. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this form is strictly prohibited. If you have received this form in error, please notify us immediately by telephone and return the original message to the South Carolina MMA via the U.S. Postal Service. Thank you.

A. ADDITIONAL INSURED – VICARIOUS LIABILITY ENDORSEMENT OPTION:

The individual insured may choose to include the listed Healthcare Facility / Entity as an Additional Insured for Vicarious Liability by adding the **Additional Insured - Vicarious Liability Endorsement** to their policy. There is no additional charge for this Endorsement. The listed Healthcare Facility / Entity specifically named in the Declarations as an Additional Insured shall neither have its own limit of liability, nor separate coverage, but shall merely be covered for any vicarious liability arising out of the acts or omissions of the Named Insured (the individual), subject to the terms and conditions of the policy issued, to which this Endorsement is attached. Coverage for the listed Healthcare Facility / Entity ceases upon the termination of the policy issued to the Named Insured (the individual). If the policy to which this Endorsement is attached is issued on a claims-made basis and is cancelled or non-renewed, except if for non-payment of premium, the Named Insured (the individual) or the listed Healthcare Facility / Entity may exercise the option to purchase the Extended Reporting Period Endorsement (“tail coverage”).

B. INSURED INFORMATION AND COVERAGE REQUEST:

1. Individual Insured’s Name: _____
2. Individual Insured’s MMA Policy # : _____
3. Effective Date for this Change (M/D/Y): ____ / ____ / ____
4. Name of listed Healthcare Facility / Entity to be added as an Additional Insured for Vicarious Liability Only:

5. Please add the **Additional Insured - Vicarious Liability Endorsement** to my policy naming the aforementioned **Healthcare Facility / Entity** as an Additional Insured.

_____ **Important:** I understand that there will NOT be separate limits of coverage for the listed Healthcare Facility/Entity; but that the listed Healthcare Facility/Entity shall merely be covered for any vicarious liability arising out of the acts or omissions of the Named Insured (the individual), subject to the terms and conditions of the policy issued, to which this Endorsement is attached.

Initial Here

6. Please confirm the desired policy limits of liability of your MMA individual policy:
 - \$1,000,000 EACH MEDICAL INCIDENT / \$3,000,000 ANNUAL AGGREGATE
 - \$1,200,000 EACH MEDICAL INCIDENT / \$3,600,000 ANNUAL AGGREGATE
 - \$2,000,000 EACH MEDICAL INCIDENT / \$4,000,000 ANNUAL AGGREGATE
 - \$3,000,000 EACH MEDICAL INCIDENT / \$6,000,000 ANNUAL AGGREGATE

C. AUTHORIZATION:

I hereby warrant that the information contained in this endorsement request form is accurate and complete to the best of my knowledge.

Signature of Insured _____/_____/_____
Date

Acknowledgement of the listed Healthcare Facility / Entity:

Signature of Authorized Representative of the Healthcare Facility/Entity _____/_____/_____
Date

Printed Name of Authorized Representative / Title