South Carolina Medical Malpractice Association

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www.scmma.net

ALLIED HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION

Assessable Policy

Instructions

1. Please answer ALL questions completely, leaving no blanks. (Use N/A if Not Applicable)
2. If more space is needed for responses, please use the *Additional Comments Section* of this application, or continue on a separate sheet with the question noted.
3. The application must be signed and dated by the applicant and the applicant's insurance agent or broker.
4. Please submit the completed application form, along with required attachments and any additional information to the applicant's insurance agent or broker.
5. Please contact the SCMMA Underwriting Department if you have any questions.

Important: No action can be taken on this application until it is complete. "Complete" means all questions have been answered, with separate explanations provided as requested. It must be signed and dated in the appropriate places, and ALL documents listed in Section A must be attached.

A. REQUIRED ATTACHMENTS:

1. ☐ Copy of **current medical professional liability insurance declarations page** showing the type of policy form and current retroactive date.
2. ☐ Verification of or intent to obtain **Extended Reporting Endorsement** (tail coverage) from current carrier if prior coverage was claims made.
3. ☐ Copy of **Curriculum Vitae** (CV/resume).
4. ☐ Copy of **business letterhead**.
5. ☐ **Loss runs** from all previous professional liability insurers for not less than the prior 10 years. The evaluation or date of issue of such loss runs may not be more than 60 days old.
6. ☐ **National Practitioner Databank Report** (http://www.npdb.hrsa.gov or 1-800-767-6732) The evaluation or date of issue of such loss runs may not be more than 60 days old.

B. AGENT / BROKER INFORMATION

7. The completed application must be submitted to applicant's insurance agent or broker. Please record the name and contact information of applicant's agent or broker below.

Agent/Broker Name: _____

Mailing Address (Street or PO Box): _____

City: _____ State: _____ Zip: _____

Agency Contact Person: _____ Telephone #: _____

Agency Contact E-mail: _____

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

C. PERSONAL INFORMATION

8. Check if you are a:
   - ☐ Anesthesia Assistant
   - ☐ Nurse Midwife
   - ☐ Optometrist
   - ☐ Registered Nurse
   - ☐ Nurse Anesthetist
   - ☐ Nurse Practitioner
   - ☐ Pharmacist
   - ☐ Nurse Anesthetist - Independent
   - ☐ Nurse Practitioner-Independent
   - ☐ Physician Assistant
   - ☐ Midlevel Shared Limits (**Midlevel Shared Limits Request Form must be submitted with this application)**
9. Full name of applicant:
   First: _____
   Middle: _____
   Last: _____
10. Gender: ☐ Male ☐ Female
11. Date of birth (M/D/Y):_____ / _____ / _____
12. Home Address:
    Street: _____ Apt. / Unit #: _____
    City: _____ State: _____ Zip: _____
13. Telephone #: _____ 13a. Fax #: _____
14. Email address: _____
15. May we contact you by e-mail: ☐ Yes ☐ No 15a. May we contact you by fax? ☐ Yes ☐ No
16. Preceptor Physician Name & Policy Number**:** _____
17. Preceptor Email Address: _____

D. PRACTICE LOCATION(S) AND CONTACT INFORMATION:

Purpose of MMA Policy *(practice entity where you will be using the MMA policy for coverage):*

18. The precise name of applicant's practice entity:
    Name: _____
19. Practice physical address:
    Street: _____ Suite / Unit #: _____
    City: _____ State: _____ Zip: _____
20. Telephone#: _____ 20a. Fax #: _____
21. Practice email address: _____
22. May we contact you by e-mail: ☐ Yes ☐ No 22a. May we contact you by fax? ☐ Yes ☐ No
23. Practice Entity Web Address: _____

Secondary Practice Location: ***(Will you be using the MMA policy for coverage at this location also?*** □ ***Yes*** □ ***No*****)**

24. The precise name of applicant's secondary practice entity:
    Name: _____
25. Secondary practice physical address:
    Street: _____ Apt. / Unit #: _____
    City: _____ State: _____ Zip: _____

26. Telephone #: _____ 26a. Fax #: _____

27. Secondary Practice Entity Web Address: _____

28: Preferred Billing Address: ☐ Home ☐ Primary office ☐ Secondary office ☐ Other
28a. If "**Other**", please provide address: _____

29. Do you have additional office locations not listed above? ☐ Yes ☐ No
29a. If "**Yes**", list additional office locations in the *Additional Comments Section* of this application or on a separate sheet and indicate if you will be using the MMA policy for coverage at these locations.

E. COVERAGE SELECTION:

30. Have you been insured by the SCMMA or SCJUA/SCPCF previously? ☐ Yes ☐ No

30a. If "**Yes**": Prior policy # :_____ 30b. Dates of coverage (M/Y): _____ / _____ - _____ / _____

31. This application is for a: ☐ New Policy ☐ Rewrite ☐ Renewal

32. **IMPORTANT: Desired Policy Limits**

Please select and initial your choice of limits below:

☐$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_____

33. Please indicate the type of coverage you are applying for:
33a. ☐ **Occurrence coverage**
33b. ☐ **Claims-made** coverage **WITHOUT** prior acts coverage
If selecting 33b, please select one of the following:
33bi. ☐ An Extended Reporting Endorsement (tail coverage) is automatic or will be purchased from my current carrier.
Important: If previously insured on a claims-made basis, failure to obtain an Extended Reporting Endorsement will leave you without prior acts coverage.
33bii. ☐ My current policy is Occurrence coverage therefore *Prior Acts Coverage* is not applicable.
33c. ☐ **Claims-made** coverage **WITH** prior acts coverage (subject to restrictions and underwriting approval)
If selecting 33c, please complete the following:
33ci. Requested prior acts date (M/D/Y): _____ / _____ / _____
This date cannot be prior to the retroactive date shown on your current policy.

34. **Effective Date**: Requested coverage effective date (M/D/Y): _____ / _____ / _____ 12:01 a.m.
This date cannot be prior to the expiration date of your current policy. Annual policy terms begin and end on the same day of the month.

35. **Expiration date**: Requested coverage expiration date (M/D/Y): _____ / _____ / _____ 12:01 a.m.
Annual policy terms begin and end on the same day of the month.

F. RATING INFORMATION:

36. Have you ever failed any licensing or Board Certification or recertification examination? ☐ Yes ☐ No
36a. If "**Yes**", provide name(s) of exam(s) and number of times failed in the *Additional Comments Section.*

37. Have there been any changes in your specialty, classification, or practice activity within the past five years? ☐ Yes ☐ No
37a. If "**Yes**", describe the nature of the change(s) in the *Additional Comments Section*.

38. Do you assist in Major Surgery? ☐ Yes ☐ No
38a. If "**Yes**", ☐ own patients only ☐ on patients of others.

39. On the next page, please check all procedures that you provide. Failure to properly complete Page 4 may impair your coverage.

- ☐ Elective Abortions
  - ☐ Prescribe Preven, or related derivatives
  - ☐ Prescribe Mifepristone, or related derivatives in combination with cytotec
- ☐ Acupuncture
- ☐ Anesthesia
  - ☐ Spinal
  - ☐ Caudal
  - ☐ General
  - ☐ Local
  - ☐ Conscious Sedation
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
  - ☐ On Own patients
  - ☐ On Patients of Others
- ☐ Bariatric surgery
- ☐ Biopsy
  - ☐ Breast Biopsy
  - ☐ Kidney Biopsy
  - ☐ Lung Biopsy
  - ☐ Prostate Biopsy
- ☐ Blepharoplasty
- ☐ Breast Implants
  - ☐ Cosmetic _____% of practice
  - ☐ Reconstructive _____% of practice
- ☐ Bronchoscopy
- ☐ Cardiac – major surgery
- ☐ Cardiovascular disease – major surgery
- ☐ Chelation therapy (is excluded under this policy)
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Cholecystectomy, Laparoscopic
- ☐ Circumcision (other than newborns)
- ☐ Colon and rectal-major surgery
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Critical Care Specialist
- ☐ Cryosurgery (other than external lesions)
- ☐ Dermatological Surgery/Other Procedures
  - ☐ Botox
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Collagen Injections
  - ☐ Cryosurgery (superficial only)
  - ☐ Dermabrasion
  - ☐ Eye liner pigmentation
  - ☐ Fat Transfer
  - ☐ Hair transplants
  - ☐ Laser Hair Removal
  - ☐ Laser Skin Resurfacing
  - ☐ Microdermabrasion
  - ☐ Silicone Injections
  - ☐ Tumescent or Smart Liposuction
  - ☐ Mohs Surgery
  - ☐ Other: _____
- ☐ D&C
- ☐ Dermatopathology
- ☐ Echocardiography
- ☐ Electrocardiography
- ☐ Emergency medicine
- ☐ Encephalography
- ☐ Endoscopic Laser Therapy
- ☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy
- ☐ ERCP / EGD / ERC
- ☐ Exchange Transfusions in Newborns
  How many per year? _____
- ☐ Fertility Treatment
- ☐ Fluoroscopy
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Gastroscopy
- ☐ General – major surgery
- ☐ Gynecology – major surgery
- ☐ Hand – major surgery
- ☐ Head and neck – major surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip nailings
- ☐ Hospitalist
- ☐ Hyperbaric Medicine
- ☐ Hysterectomy
- ☐ Hysteroscopy
- ☐ Intensivist
- ☐ Intensive care for newborns within a Tertiary Care Unit
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ Laryngology – major surgery
- ☐ Laser Surgery
- ☐ Left Heart Catheterization
- ☐ Liposuction
- ☐ Lithotripsy
- ☐ Lumbar Fusion
- ☐ Mammography
- ☐ Myelography
- ☐ Myomectomy
- ☐ Neonatology
- ☐ Neurology – major surgery
- ☐ Norplant Insertion/Extraction
- ☐ Obstetrics/Gynecology – major surgery
  - ☐ Normal deliveries
  - ☐ C-Sections
  - ☐ VBAC

  By induction? ☐Y ☐N

  Induction agent:_____
- ☐ Ophthalmology – major surgery
- ☐ Organ Transplant
- ☐ Orthopedic – major surgery
  - ☐ With Back & Spine
  - ☐ No Back & Spine
- ☐ Osteopathic manipulative medicine
- ☐ Otology – major surgery
- ☐ Otorhinolaryngology – major surgery
  - ☐ Including elective cosmetic procedures
  - ☐ Not including elective cosmetic procedures
- ☐ Pain Management
  - ☐ Medication Only
  - ☐ IDD Therapy
  - ☐ Facet Blocks
  - ☐ Selective Nerve Root Blocks
  - ☐ Rhizotomy
  - ☐ Spinal Injections
  - ☐ Dorsal Root Gangliotomies
  - ☐ Thoracic Sympathectomies
  - ☐ Spinal Cord Stimulators
  - ☐ Implantation/Removal of Drug Infused Pumps
  - ☐ Sphenopalatine Lesioning
  - ☐ Trigeminal Lesioning
  - ☐ Cordotomies
  - ☐ Other _____
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Percutaneous vertebroplasty
- ☐ Permanent Pacemaker
- ☐ Plastic – major surgery
- ☐ Polypectomy
- ☐ Prenatal Care (Past 1st Trimester)
- ☐ Prolotherapy
- ☐ Radiation/X-ray Therapy
- ☐ Radiopaque Dye
- ☐ Rapid Opiate Detoxification
- ☐ Rhinology – major surgery
- ☐ Robotics utilized
- ☐ Roux-en-y
- ☐ Sclerotherapy
- ☐ Scoliosis Surgery
- ☐ Shock Therapy
- ☐ Sterilization procedures
- ☐ Thoracic surgery _____ %
- ☐ Thyroidectomy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Transgender surgery and/or hormonal gender conversion
- ☐ Trigger point injections
- ☐ Tubal ligation
- ☐ Urgent Care Medicine
- ☐ Urology – major surgery
- ☐ Vascular surgery _____%
- ☐ Vasectomy
- ☐ Weight Control _____%
  - ☐ Bariatric Bypass
  - ☐ Gastric Bubble or Jejuno-Ileal Bypass
  - ☐ Gastric Stapling
  - ☐ Gastric Banding ☐

  Other
  - ☐ Medications Prescribed (please list):_____
    _____
    _____
    _____
- ☐ None of the above applies to my practice.
- ☐ Other Procedures (List):
  _____
  _____
  _____
  _____
  _____

G. PRACTICE INFORMATION

40. Indicate the average weekly numbers under each of the following categories.
    40a. Number of scheduled patients seen per week: _____
    40b. Number of walk-in patients seen per week: _____
    40c. Number of hours worked per WEEK: _____

41. Are you applying for part time coverage? ☐ Yes ☐ No
    41a. If "**Yes**", please indicate the number hours worked per MONTH: _____
    41b. If "**Yes**", please provide name and contact information for individual the SCMMA may contact for audit of records:
    Name: _____ Telephone #: _____
    41c. Check applicable part time level for which you are applying:

    ☐ 50% discount (up to 21 hours per month) ☐ 40% discount (22 to 43 hours per month) ☐ 30% discount (44 to 85 hours per month)

42. Are you employed full-time or part-time by the Federal, State, or Local Government or are you in active duty in the military services? ☐ Yes ☐ No
    42a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    42b. If "**Yes**", provide details in the Additional Comments Section and note if coverage is provided by the Federal Tort Claims Act. Attach verification of coverage, if applicable.

43. Do you perform medical or surgical procedures at a surgery center, office-based surgical suite, or similar facility? ☐ Yes ☐ No
    43a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    43b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

44. Do you perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? ☐ Yes ☐ No
    44a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    44b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage.

45. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
    45a. If "**Yes**", do you see these patients: (Please check one.) ☐ in your office, or ☐ at the correctional facility?

46. Are you engaged in "moonlighting" activities or performing activities other than reported above which will be covered by another professional liability policy? ☐ Yes ☐ No
    46a. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage.

H. PROFESSIONAL INFORMATION:

47. Please answer "**Yes**" or "**No**" to all of the questions on Section "H". If your answer is "**Yes**" to any of the questions in this section, please indicate the date and state (if applicable) where action occurred. Please give full details on the *Additional Comments Section*. (Note: The "numerical sequence" of questions in this section is intentionally different from the rest of the application.)

A. 1. Have you had a denial, restriction, suspension, probation, or revocation of privileges by a hospital or other health care facility? ☐ Yes ☐ No
    If **"Yes"**: Date: _____ State: _____

2. Have you entered into any consent agreement that has adversely affected your privileges with any formal committee of a hospital or other health care facility? ☐ Yes ☐ No
    If **"Yes"**: 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
    If **"Yes":** 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
If **"Yes":** 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
If **"Yes":** 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
If **"Yes":** 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
If **"Yes":** Date: _____

6. Have you been declined, non-renewed, or cancelled by an insurance carrier with cause (excluding market withdrawal)? ☐ Yes ☐ No
If "**Yes**": 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
If "**Yes**": Date of incident/alleged injury: _____ / _____ / _____ Date reported: _____ / _____ / _____
Insurance carrier: _____

8. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any mental illness, including but not limited to depression? ☐ Yes ☐ No
If "**Yes"**, has a relapse occurred following your initial treatment? ☐ Yes ☐ No

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
If **"Yes":** Date: _____ State: _____

2. Have you been convicted of or pled guilty to a felony, convicted of or pled guilty to a criminal offense for which one of the elements is fraud or misrepresentation, or have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment or sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? ☐ Yes ☐ No
If **"Yes":** Date: _____ State: _____

Note: Answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.

3. Have you been accused of or been found to have altered health care records? ☐ Yes ☐ No
If **"Yes":** Date: _____

I. MEDICAL TRAINING AND WORK HISTORY:

48. Professional or Technical School Information:

	Name of Professional or Technical School(s) Attended	Location	Degree	Date Graduated
48a.				
48b.				
48c.				

49. List all states where you are licensed to practice medicine and your license numbers: **Important**: 80% of your practice must be in South Carolina. We will allow 20% of your practice to be across the state line. This typically occurs in the border areas of Charlotte (Rock Hill); Augusta (North Augusta); and Savannah (Hilton Head). **All** out of state exposure must have prior approval by the MMA.

	State	License Number	Status Code	Percentage (%) of Patients Seen, Examined or Treated in Each State**.**
49a.				
49b.				
49c.				

*Status Code - **A** = Active, **I** = Inactive, **P** = Pending, **T** = Temporary

50. Work History:

List all locations (City and State) where you have practiced in the last five years. List most recent location first. Do not include training programs but include all moonlighting positions.	Start Date and End Date (m/y)

J. PROFESSIONAL LIABILITY INSURANCE HISTORY:

51. Have you ever practiced without professional liability coverage? ☐ Yes ☐ No
    51a. If "**Yes**", provide details in the *Additional Comments Section.*

52. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage (tail coverage)? ☐ NA ☐ Yes ☐ No
    52a. If "**Yes**", provide details in the *Additional Comments Section.*

53. 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
    53a. If "**Yes**", provide details in the *Additional Comments Section.*

54. Please provide information on your Professional Liability Insurance carrier for the previous five years**:**

Important: If you are a new applicant, this section must be completed.

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made
Effective Date Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	❑ Yes ❑ No ❑ NA	❑ Yes ❑ No ❑ NA	❑ Yes ❑ No ❑ NA	❑ Yes ❑ No ❑ NA	❑ Yes ❑ No ❑ NA

K. PRACTICE ORGANIZATION:

55. Please check the boxes under 55a and 55b that best describe your primary practice affiliation(s):

55a. **Employment Status**

- ☐ Employee
- ☐ Shareholder/partner
- ☐ Independent contractor
- ☐ Solo unincorporated/sole proprietor
- ☐ Intern/resident/fellow
- ☐ Other: _____

55b. **Entity Type**

- ☐ Professional association
- ☐ Multi-shareholder corporation, partnership, LLC
- ☐ Solo incorporated - no employed or contracted dentists
- ☐ Hospital owned
- ☐ Government owned
- ☐ Industrial
- ☐ Other: _____

56. Name of primary practice/entity organization:_____

57. Is the purpose of the entity named in question 56 other than a medical office practice? ☐ Yes ☐ No

58. Does the entity named in question 56 currently maintain professional liability coverage? ☐ Yes ☐ No
    58a. If "**Yes**", is this coverage: ☐ Occurrence, or ☐ Claims-Made?
    58b. If "**Claims-Made**", what is the retroactive date used by the current carrier (M/D/Y): _____ / _____ / _____

59. Date of Incorporation (M/D/Y): _____ / _____ / _____

60. Federal Tax Identification Number: _____

61. Are you in any way affiliated with a Medical Spa or Weight Loss Facility? ☐ Yes ☐ No
    61a. If "**Yes",** please explain in the *Additional Comments Section*.

62. **Do you desire coverage for the business entity named in question 56 above?** ☐ Yes ☐ No
    62a. If "**Yes**", do you wish to share your individual policy limits with this business entity? ☐ Yes ☐ No
    If "**No**", and separate limits are desired, you must purchase a separate practice entity policy.

63. **Do you wish to add the Employees as Additional Insureds Endorsement?** ☐ Yes ☐ No

The **Employees as Additional Insureds Endorsement** ("Staff Coverage") extends individual coverage to *eligible* employees for claims that arise from duties performed within the scope of their work for the practice. It also extends coverage to the employer for vicarious liability that may be imputed to them by these employees' actions. *Eligible* employees include RNs, LPNs, surgical techs, medical assistants, lab techs, X-ray techs, hygienists, dental assistants, and administrative staff.

IMPORTANT: Physicians, dentists, podiatrists, optometrists, pharmacists, chiropractors, physician assistants, nurse practitioners, nurse midwives, nurse anesthetists, anesthesia assistants, and perfusionists are **NOT** eligible for individual coverage under this endorsement.

All of the above (except chiropractors and perfusionists) may apply for individual coverage from the MMA. Different applications may be required depending on medical specialty. Contact the MMA Underwriting Department or visit *www.scmma.net* for more information and applications.

L. CLAIMS HISTORY:

Important: The words "claim" and "circumstance" as used in Questions 64 and 65 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.

Important: Please complete the attached *Malpractice Claims History Explanation Form on the following page* for each case reported in 64a*iii (below).*

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

64a. If "**Yes**", please indicate number of cases below:

		Location (County and State)
i.	Current number open**:** _____	_____
ii.	Current number closed: _____	_____
iii.	Total number of cases: _____ (*i +ii*)	_____

64b. If "**Yes"**, have all been reported to your current or prior professional liability insurer? ☐ NA ☐ Yes ☐ No

65. Other than the claims/suits indicated in question 64 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

65a. If "**Yes"**, how many? _____ (*Please attach details of each circumstance*.)

65b. If "**Yes"**, have all been reported to your current or prior professional liability insurer? ☐ NA ☐ Yes ☐ No

65c. If all have **not** been reported to your current or prior professional liability insurer, please explain in *Additional Comments Section* or on separate sheet.

66. 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
- permanent damage to a patient related to an injury during the delivery of a child or as the result of the administration of anesthesia. ☐ Yes ☐ No
- limitations on a patient's activities of daily living (including the loss of a limb). ☐ Yes ☐ No
- the death of a patient. ☐ Yes ☐ No

M. MALPRACTICE CLAIMS HISTORY EXPLANATION FORM:

Important: Please photocopy this form as needed and complete one for EACH case, potential claim, or suit reported that is referenced in questions 64 and 65 above. All questions must be answered or marked not applicable (NA).

Patient's name: _____ Date of incident and your treatment (M/D/Y): _____ / _____ / _____

Name of insurance carrier:_____ File number: _____ Telephone: _____

Address of insurance carrier: _____

Date reported to insurance company (M/D/Y) _____ / _____ / _____

Date of incident, treatment and/or surgery (M/D/Y): _____ / _____ / _____

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)

❑ Incident report only	❑ Suit threatened, no action taken	❑ Suit filed but dropped by claimant
❑ Summary judgment in your favor	❑ Jury verdict in your favor	❑ Jury verdict in favor of the plaintiff
❑ Suit settled out of court	❑ Suit filed awaiting mediation	❑ 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: $_____

Additional comments regarding this claim:

_____

_____

_____

_____

_____

_____

_____

N. ADDITIONAL COMMENTS SECTION:

Section Question # Explanation/Comments

O. AGREEMENT AND AUTHORIZATION:

_____ Initial here

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.

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

_____ Initial here

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 may have occurred but have not yet been reported.

_____ Initial here

C. Signing this application does not bind the MMA 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 Association and that my MMA 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 MMA or any of its brokers/agents relating to this insurance.

_____ _____ / _____ / _____
Signature of MMA Applicant Date

Agent/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 Agent/Broker Date