South Carolina Medical Malpractice Association
550 South Main Street, Suite 525, Greenville, SC 29601 ***corporate office***
864.240.5449 ***main*** **864-240-2750** ***fax***
www.scmma.net

SC MMA
DENTIST AND ORAL SURGEON 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. Full name of applicant:

First: _____

Middle: _____

Last: _____

9. Gender: ☐ Male ☐ Female 9a. Date of birth (M/D/Y): ____/____/____

10. Professional Designation: ☐ D.M.D. ☐ D.D.S.

11. Home Address:

Street: _____ Apt. / Unit #: _____

City: _____ State: _____ Zip: _____

12. Telephone #: _____ 12a. Fax #: _____

13. Email address: _____

14. May we contact you by e-mail: ☐ Yes ☐ No 14a. May we contact you by fax? ☐ Yes ☐ No

D. PRACTICE LOCATION(S) AND CONTACT INFORMATION:

Primary Practice Location:

15. The precise name of applicant's primary practice entity:

Name: _____

16. Primary practice physical address:

Street: _____ Suite / Unit #: _____

City: _____ State: _____ Zip: _____

17. Telephone #: _____ 17a. Fax #: _____

18. Primary practice email address: _____

19. May we contact you by e-mail: ☐ Yes ☐ No 19a. May we contact you by fax? ☐ Yes ☐ No

20. Practice Entity Web Address: _____

Secondary Practice Location:

21. The precise name of applicant's secondary practice entity:

Name: _____

22. Secondary practice physical address:

Street: _____ Apt. / Unit #: _____

City: _____ State: _____ Zip: _____

23. Telephone #: _____ 23a. Fax #: _____

24. Secondary Practice Entity Web Address: _____

25: Preferred Billing Address: ☐ Home ☐ Primary office ☐ Secondary office ☐ Other

25a. If "**Other**", please provide address: _____

26. Do you have additional office locations not listed above? ☐ Yes ☐ No

26a. If "**Yes**", list additional office locations in the *Additional Comments Section* of this application or on a separate sheet.

E. DENTISTS AND ORAL SURGEONS COVERAGE SELECTION:

Important:

SC MMA offers Dentists and Oral Surgeons a range of limits to choose from. Please select and initial in the blank 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 _____

27. Have you been insured by the SCMMA or SC JUA before: ☐ Yes ☐ No

27a. If "**Yes**": Prior policy #:_____ 27b. Dates of coverage (M/Y): _____/_____-_____/_____

28. Is this application for a: ☐ New Policy ☐ Re-write ☐ Renewal

29. Please indicate the type of coverage you are applying for:

29a. ☐ **Occurrence coverage**

29b. ☐ **Claims-made** coverage **WITHOUT** prior acts coverage

If selecting 29b, please select one of the following:

29bi. ☐ 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.

29bii. ☐ My current policy is on an occurrence form; therefore, *Prior Acts Coverage* is not applicable.

29c. ☐ **Claims-made** coverage **WITH** prior acts coverage (subject to restrictions and underwriting approval)

If selecting 29c, please complete the following:

29ci. Requested prior acts date (M/D/Y): _____/_____/_____
This date cannot be prior to the retroactive date shown on your current policy.

30. **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.

31. **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:

32. What is your present specialty?_____ Percentage of Practice?_____%

33. Are you American Board Certified? ☐ Yes ☐ No

33a. If "**Yes**", Specialty Board: _____

33b. If "**Yes**", Date Certified:_____/_____/_____

33c. If "**No**", are you board eligible? ☐ Yes ☐ No

33d. If not board eligible, provide explanation in the *Additional Comments Section*.

34. Have you ever failed any licensing or Board Certification or recertification examination? ☐ Yes ☐ No

34a. If "**Yes**", provide name(s) of exam(s) and number of times failed in the *Additional Comments Section.*

35. Have there been any changes in your specialty, classification, or practice activity within the past five years? Yes ☐ No ☐

35a. If "**Yes**", describe the nature of the change(s) in the *Additional Comments Section*.

36. COSMETIC EXPOSURE: Will you do procedures involving the use of Dermal Fillers? ☐ Yes ☐ No

36a. By signing and dating below you are confirming that you have read, understood and are in compliance with The South Carolina Board of Dentistry

POLICY ON BOTOX AND OTHER INJECTABLES. For a copy of this policy or more information, please contact the South Carolina Board of Dentistry, 803-896-4599.

_____ _____

Signature of Applicant Date of Signature

37. SPECIALTY CLASS: Please check the appropriate class in the far right column below. Any Procedure or Anesthesia in a higher class would make the higher class applicable.

Important: Please contact the MMA at 864-240-5449 if you have any questions regarding your performance of procedures within the following classifications. Failure to properly complete this section may impair your coverage.

Class	Procedure and / or Specialty	Anesthesia	Check Appropriate Class
1	General Dentistry Endodontics Pediatrics Prosthodontics Orthodontics Periodontics / Non-Osseous Surgery, Non-Advanced or Non-Refractory Progressive Periodontitis Prostheses / Non-Surgical Removal of Impacted Wisdom Teeth Soft Tissue Only	In the office: Local Nitrous Oxide Oral Conscious IV Administered in the hospital by other than an insured or insured's employee: General Deep Intra Muscular (I.M.)	_____ (1)
2	Periodontics / Osseous Surgery, Advanced or Refractory Progressive Periodontitis Removal of Impacted Wisdom Teeth, Other than Soft Tissue	Conscious I.M. in the office	_____ (2)
2A	Implants / Surgical		_____ (2A)
3	Oral Surgeon Maxillofacial Surgery	General Anesthesia and / or Deep Sedation given in a dosage to render the patient unconscious and done in the office, or in a hospital if administered by an insured or insured's employee.	_____ (3)

Other Procedures Not Listed: _____

_____

_____

Have you provided documentation to the Dental Board as to your training, education and qualifications before undertaking to perform these procedures?____Yes____No Are all procedures limited to the perioral areas?____Yes____No

G. PROFESSIONAL EMPLOYEES AND INDEPENDENT CONTRACTORS

38. Please list below the names of all Dentists and Oral Surgeons who are associated with your primary practice entity. You must check whether the participant is a member/owner (an individual who has an ownership interest in the practice), or an employee (an individual who does not have an ownership interest). NOTE: Independent contractors are considered to be employees for underwriting purposes.

	NAME	SPECIALTY	MEMBER/OWNER	EMPLOYED	MMA INSURED
38a.	_____	_____	☐	☐	☐ Yes ☐ No
38b.	_____	_____	☐	☐	☐ Yes ☐ No
38c.	_____	_____	☐	☐	☐ Yes ☐ No

If more space is needed, continue on a separate sheet. Please inform the MMA of any changes as they occur.

Important: *If "**NO**" is indicated under "MMA Insured" for any professional listed above, please attach a copy of that individual's most recent medical professional liability insurance declarations page or certificate of insurance with this application.* Each partner, employed or contracted dentist or oral surgeon who desires SCMMA coverage is required to submit an individual application.

39. **Important**: Complete Question #39-41 only if you are the employer and you do not have a separate professional liability policy for your practice entity.

An employer may incur a legal responsibility for the actions of his/her employee(s) or independent contractors. Additional charges may be applied to practice entity policies to reflect this exposure. The additional charges extend coverage to the employer for vicarious liability that may be imputed to them by employee actions. Do you employ or contract any of the following? NOTE: Independent contractors are considered to be employees for underwriting purposes.

a.	Surgical Technician	☐ Yes	☐ No	How Many? _____
b.	Anesthesiologist	☐ Yes	☐ No	How Many? _____
c.	Nurse Anesthetist / Anesthesia Assistant	☐ Yes	☐ No	How Many? _____
d.	Licensed Estheticians	☐ Yes	☐ No	How Many? _____
e.	Other (Please specify)	_____		

40. **Important**: If **"Yes"** to any of the above, please list the individual name(s), specialty, carrier, policy number and the limits of coverage in the space provided below The practice entity policy form does NOT extend individual coverage to these individuals.

Name	Specialty	Carrier Name	Policy #	Limits
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If more space is needed, continue on a separate sheet. Please inform the MMA of any changes as they occur.

41. **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 covered practice entity. 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 JUA Underwriting Department or visit SCMMA.NET for more information and applications.

H. PRACTICE ORGANIZATION:

42. Please check the boxes under 42A and 42b that best describe your primary practice affiliation(s):

42a. **Employment Status**

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

42b. **Entity Type**

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

43. Name of primary practice/entity organization: _____

44. Is the purpose of the entity named in question #43 other than a dental office practice? ☐ Yes ☐ No

45. Do you have any office or expense sharing arrangements with any other dentist(s) or Oral surgeon(s) not disclosed? ☐ Yes ☐ No

46. Are there any subsidiaries of this business entity that provide health care related services? ☐ Yes ☐ No
46a. If "**Yes**", please list subsidiary name (s) and a brief description of services in *Additional Comments Section*.

47. Is the entity eligible to be licensed to provide medical professional services? ☐ NA ☐ Yes ☐ No
47a. If "**Yes**", attach a copy of the license to the application.

48. Does the applicant's primary practice entity (named in question #43) currently maintain professional liability coverage? ☐ Yes ☐ No
48a. If "**Yes**", is this coverage: ☐ Occurrence or ☐ Claims-Made?
48b. If "**Claims-Made**", what is the retroactive date used by the current carrier (M/D/Y): _____/_____/ _____

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

50. Federal Tax Identification Number: _____

51. Do you desire coverage for the business entity named in question #43 above? ☐ Yes ☐ No
51a. 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.

I. PRACTICE INFORMATION:

52. Indicate the average weekly numbers under each of the following categories.
52a. Number of scheduled patients seen per week: _____
52b. Number of walk-in patients seen per week: _____
52c. Number of hours worked per week: _____

53. Are you applying for part time coverage? ☐ Yes ☐ No
53a. If "**Yes**", please indicate the number hours worked per month: _____
53b. If "**Yes**", please provide name and contact information for individual the SC MMA may contact for audit of records:
Name: _____ Telephone #: _____
Address: _____

54. Are you permanently retired from the practice of dental medicine? ☐ Yes ☐ No

55. 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
    55a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    55b. 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.

56. Do you perform dental or surgical procedures at a surgery center, office-based surgical suite, hospital, or similar facility? ☐ Yes ☐ No
    56a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    56b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

57. 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 dental services, dental opinions or dental advice? ☐ Yes ☐ No
    57a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    57b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage.

58. Do you read, interpret or diagnose films, slides or specimens taken from patients who are being treated in other states? ☐ Yes ☐ No
    58a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    58b. If "**Yes**", provide details in the *Additional Comments Section,* and attach verification of coverage.

59. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
    59a. If "**Yes**", do you see these patients: (Please check one.) ☐ in your office, or ☐ at the correctional facility?

60. Do you provide clinical services to any nursing home, hospice, sanitarium or similar facility? ☐ Yes ☐ No
    60a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    60b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

61. Do you participate in pharmaceutical testing programs/clinical investigation studies with drugs that are not FDA approved? ☐ Yes ☐ No
    61a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    61b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable, and copy of the indemnification agreement provided by the pharmaceutical company.

62. Do you own or operate a surgery center, facility, laboratory, or other outpatient facility? ☐ Yes ☐ No
    62a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    62b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

63. Are you engaged in "moonlighting" activities or performing activities other than reported above which will be covered by another professional liability policy? ☐ Yes ☐ No
    63a. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage

J. DENTAL TRAINING AND WORK HISTORY:

64. Are you entering private practice for the first time? ☐ Yes ☐ No

65. List all states where you are licensed to practice dentistry 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.
65a.				
65b.				
65c.				

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

66. Dental School Information:

	Name of Professional School(s) Attended	Location	Degree	Date Graduated
66a.				
66b.				

67. 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)

K. PROFESSIONAL INFORMATION:

68. Please answer "**Yes**" or "**No**" to all of the questions on Section "K". 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 dentistry 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 dental 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
"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 ☐ Yes ☐ No

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?
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:_____/_____/_____

L. PROFESSIONAL LIABILITY INSURANCE HISTORY

69. Have you ever practiced without professional liability coverage? ☐ Yes ☐ No
69a. If "**Yes**", provide details in the *Additional Comments Section.*

70. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage (tail coverage)? ☐ NA ☐ Yes ☐ No
70a. If "**Yes**", provide details in the *Additional Comments Section.*

71. 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
71a. If "**Yes**", provide details in the *Additional Comments Section.*

72. If prior carrier was **not** the SC JUA, 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

M. CLAIMS HISTORY

Important: The words "claim" and "circumstance" as used in Questions 73 and 74 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/dental records or expressing dissatisfaction regarding your medical/dental 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* for each case reported in 73a*iii on the following page.*

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

73a. 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*)	

73b. If "**Yes"**, have all been reported to your current or prior professional liability insurer? ☐ NA ☐ Yes ☐ No

74. Other than the claims/suits indicated in question 73 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

74a. If "**Yes"**, how many? (*Please attach details of each circumstance*.)

74b. If "**Yes"**, have all been reported to your current or prior professional liability insurer? ☐ NA ☐ Yes ☐ No

74c. If all have **not** been reported to your current or prior professional liability insurer, please explain in *Additional Comments Section* or on separate sheet.

75. 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 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

N. 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 73 and 74 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/dental 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:

_____

_____

_____

O. ADDITIONAL COMMENTS SECTION:

Section	Question #	Explanation/Comments

P. 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 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

The information contained in this application 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 application is strictly prohibited. If you have received this application in error, please notify The South Carolina MMA immediately by telephone and return the original message to us via the U.S. Postal Service. Thank you.