South Carolina Medical Malpractice Association

550 S. Main Street, Suite 525, Greenville, SC 29601 *corporate office*
864.240.5449 *main* **864.240.2750** *fax*

Website: **www.scmma.net** *Email:* **Admin.SCMMA@marsh.com**

ENTITY SHARED LIMITS ENDORSEMENT REQUEST FORM

Instructions

1. Please read Section "A" carefully, and call the MMA if you have questions.
2. Please complete, sign and date this form then scan/email to Admin.SCMMA@marsh.com
3. If more space is needed for responses, please continue on a separate sheet with the question # noted.
4. The endorsement request must be signed and dated by the Insured.
5. If available, please attach a copy of your business letterhead that includes a list of all licensed healthcare providers in the practice.

***IMPORTANT**:* If switching to shared limits, all individually insured physicians and mid-levels should have this endorsement added to their policy whether they are insured by the MMA or another carrier. Failure to do so may result in a gap in coverage.

TO:

Admin.SCMMA@marsh.com MMA Underwriting Department

____

FROM:

____ Date: _____ / _____ / _____

Authorized Practice Representative Name

PRACTICE NAME: ____

INDIVIDUAL INSURED'S NAME: ____

Phone:____

Email:____ Total # of Pages: __________

The information contained in this transmission 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 transmission is strictly prohibited. If you have received this transmission 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. ENTITY SHARED LIMITS ENDORSEMENT OPTION:

The individual insured may choose to insure the professional association, corporate entity, or other legal practice entity by adding the **Shared Limits Endorsement** to his/her policy. There is no additional charge for this endorsement. Under most circumstances, the blanket employee coverage, **Employees as Additional Insureds Endorsement**, should be added to the individual policy as well. The additional premium for the Employees as Additional Insureds Endorsement is 1% of the total premium subject to a minimum premium of $100. Each entity, corporation, partnership, or professional association specifically named in the Declarations as the Additional Insured shall not have its own limit of liability, but shall share in the limits of liability of the Named Insured (the individual). Coverage to the organization ceases upon the termination of the individual's policy. If you have a claims-made policy and it is cancelled or non-renewed, except if for non-payment of premium, the individual or the 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 Practice Entity: ______________________________
5. Check below if applicable:

5a. ☐ Please **discontinue** the separate practice policy #________________________, for the above named practice entity.

5b. ☐ Please add the Shared Limits Endorsement to my policy naming the aforementioned **entity** as an Additional Insured.

5c. ☐ Please add the **Employees as Additional Insureds Endorsement** ("staff" coverage) to my individual policy.

_______ **Initial Here** — **Important**: I understand that the additional premium charge for adding the staff coverage is 1% of policy premium subject to a minimum premium of $100. I understand that I will not have separate limits for my entity, but my entity and I will share in the limits of liability under my MMA coverage.

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

D. 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