South Carolina Medical Malpractice Association

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

HEALTHCARE FACILITY PROFESSIONAL LIABILITY INSURANCE APPLICATION - RENEWAL

Assessable Policy

IMPORTANT: *This is a RENEWAL application for medical professional liability insurance from the SCMMA. It is intended for use by outpatient surgery centers, diagnostic centers, endoscopy centers, free/non-profit clinics and other facilities who are currently insured by the SCMMA. Payment must be received by the SCMMA before coverage can be bound.*

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 have your agent submit the completed application, along with required attachments and any additional information to the SCMMA. Contact the SCMMA if you have any questions.
5. Please return completed application to Admin.SCMMA@marsh.com

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 by both the applicant and agent.*

A. AGENT/BROKER INFORMATION

1. 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		
Class Code	Policy Fee	Total Annual Premium
Other	Other	Endorsements:

B. Practice Location and General Information:

2. Applicant is: ☐ For Profit ☐ Non Profit ☐ Free Clinic ☐ Governmental
3. Type of Facility: ☐ Outpatient Surgery Center ☐ Diagnostic Center ☐ Endoscopy Center ☐ Free/Non Profit Clinic ☐ Other
   3a. If "**Other**", please describe: ______
4. Briefly describe nature of services provided:
   ______
   ______
   ______

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application.

5. The legal/corporate name of the applicant facility:
   Name: ______ 5a. Federal Tax ID #: ______
6. Preferred Billing Address (Your invoice will be mailed to this address.)
   P.O. Box or Street: ______ Suite #: ______
   City: ______ State: ______ Zip: ______
7. Practice Address:
   Street Address 1: ______ Suite #: ______
   Street Address 2: ______
   City: ______ State: ______ Zip: ______
8. Office Telephone #: ______ 8a. Fax #: ______
   8b. May we contact you by fax? ☐ Yes ☐ No
9. Contact Name: ______ 9a. Contact Title: ______
10. Contact Email: ______ 10a. May we contact you by email? ☐ Yes ☐ No
11. Facility/Entity Web Address: ______
12. Do you have additional practice locations not listed above? ☐ Yes ☐ No
    12a. If "**Yes**", please list additional offices in *Additional Comments Section.*

C. Policy and Coverage History

POLICY LIMITS DESIRED: ◯***$1M/$3M*** ◯***$1.2M/$3.6M*** ◯***$2M/$4M*** ◯***$3M/$6M***

Current MMA policy #: ______

13. **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.
14. **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.

16. 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
    16a. If **"Yes",** please explain in the *Additional Information Section*.

17. 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
    17a. If **"Yes"**, please explain in the *Additional Comments Section.*

18. Has your facility ever operated without professional liability coverage? ☐ Yes ☐ No

D. FOR-PROFIT FACILITY RATING INFORMATION: *(COMPLETE SECTION "D" ONLY IF APPLICANT IS A FOR-PROFIT ENTITY)*

19. Please indicate the annual number of patient visits for the applicant facility:

	FACILITY TYPE	NUMBER PER YEAR
a.	Outpatient Surgery Centers	
	ai. Outpatient surgeries	________________
	aii. Pain management procedures	________________
b.	Diagnostic Centers – outpatient visits	________________
c.	Endoscopy Centers – outpatient visits	________________
d.	Medical Research Centers – outpatient visits	________________
e.	Other Facility - outpatient visits	________________

20. Do you participate in pharmaceutical testing programs/clinical investigation studies with drugs that are not FDA approved? ☐ Yes ☐ No
    20a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    20b. 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.

21. Please list below the names of all **physicians**/**dentists**/**podiatrists**/**optometrists** and **pharmacists** who have privileges at your facility. You must check whether the participant is an owner (an individual who has an ownership interest in the facility), or a non-owner (an individual who does not have an ownership interest).

	NAME	SPECIALTY	OWNER	NON-OWNER	MMA INSURED
a.	____________________	____________________	☐	☐	☐ Y ☐ N
b.	____________________	____________________	☐	☐	☐ Y ☐ N
c.	____________________	____________________	☐	☐	☐ Y ☐ N
d.	____________________	____________________	☐	☐	☐ Y ☐ N
e	____________________	____________________	☐	☐	☐ Y ☐ N
f.	____________________	____________________	☐	☐	☐ Y ☐ N
g.	____________________	____________________	☐	☐	☐ Y ☐ N

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application. Please inform the MMA of any changes as they occur.

IMPORTANT: *If "NO" is indicated under "MMA Insured" for any medical 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.*

22 Please list any additional owners of the applicant facility not shown in question #21 above.

	NAME		
a.	____________________	d.	____________________
b.	____________________	e.	____________________
c.	____________________	f.	____________________

23. A facility may incur vicarious liability for the actions of its employee(s) or independent contractors (I/C). Additional charges may be applied to a facility policy to reflect this exposure. Does the applicant facility employ or contract any of the following?

		NA	Employed	I/C	How Many?
a.	Surgical Technician	☐	☐	☐	# Full Time _____ # Part Time:_____
b.	Other Technician: (x-ray, nuclear, path, sono, other)	☐	☐	☐	# Full Time _____ # Part Time:_____
c.	Anesthesiologist	☐	☐	☐	# Full Time _____ # Part Time:_____
d.	Nurse Anesthetist / Anesthesia Assistant	☐	☐	☐	# Full Time _____ # Part Time:_____
e.	Nurse Practitioner	☐	☐	☐	# Full Time _____ # Part Time:_____
f.	Physician Assistant	☐	☐	☐	# Full Time _____ # Part Time:_____

24. If applicant facility employs or contacts any professionals in "c" through "f" above, please list the individual name(s), specialty, carrier, policy number and the limits of coverage in the space provided below. The SCMMA Facility Policy does NOT extend individual coverage to these individuals.

	Employee Name	Specialty	Carrier Name	Policy #	Limits
a.	________________	__________	______________	_______	______
b.	________________	__________	______________	_______	______
c.	________________	__________	______________	_______	______

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application. Please inform the MMA of any changes as they occur.

25. The **Employees as Additional Insureds** ("Staff Coverage") **Endorsement** extends individual coverage to *eligible* employees for claims that arise from duties performed within the scope of their work for the facility. 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. Most facilities should have this coverage.

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

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.

E. NON-PROFIT FACILITY RATING INFORMATION: *(COMPLETE SECTION "E" ONLY IF APPLICANT IS A NON-PROFIT ENTITY)*

26. For underwriting purposes, a Full Time Equivalent (FTE) "Slot" is equal to 1,600 Employee/Volunteer hours per year. One Full Time Equivalent (FTE) Slot could cover several providers.

	TYPE (1,600 hours per year)	NUMBER
a.	Physician FTE Slots	________
b.	Nurse Practitioner FTE Slots	________
c.	Dentist FTE Slots	________
d.	Pharmacist FTE Slots	________
e.	Physician Assistant FTE Slots	________

27. Please indicate the annual number of patient visits at your facility: ____________________

28. What are your days/hours of operation? ____________________

29. Please list the names of all licensed healthcare providers who volunteer at your clinic, their specialty, whether they are still in private practice or retired, and if they are currently insured by the MMA.

	NAME	SPECIALTY	Private Practice	Retired/Other	MMA INSURED
a.	______________	______________	☐	☐	☐ Y ☐ N
b.	______________	______________	☐	☐	☐ Y ☐ N
c.	______________	______________	☐	☐	☐ Y ☐ N
d.	______________	______________	☐	☐	☐ Y ☐ N
e.	______________	______________	☐	☐	☐ Y ☐ N

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application. Please inform the MMA of any changes as they occur.

IMPORTANT: *If "**NO**" is indicated under "MMA Insured" for any medical 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. Their employer paid medical malpractice insurance may not extend to a volunteer activity; therefore the provider may need to have coverage under an FTE Slot.*

30. A facility may incur vicarious liability for the actions of its employee(s) or volunteers. Additional charges may be applied to a facility policy to reflect this exposure. Does your facility utilize and of the following?

		NA	Employed	Volunteer	How Many?	
a.	X-Ray Technician	☐	☐	☐	# Full Time _____	# Part Time:_____
b.	Pathology Technician	☐	☐	☐	# Full Time _____	# Part Time:_____
c.	Psychologist/Counselor	☐	☐	☐	# Full Time _____	# Part Time:_____

31. Do you use any anesthesia services? ☐ Yes ☐ No

31a. If "**yes**", please describe: ____

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

Do you wish to include staff coverage with the **Employees as Additional Insureds Endorsement**? ☐ Yes ☐ No

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 be covered under a Full Time Equivalent (FTE) Slot.*

33. Please list the names of the individuals who serve on your Board:

NAMES

a.	______________________	g.	______________________
b.	______________________	h.	______________________
c.	______________________	i.	______________________
d.	______________________	j.	______________________
e.	______________________	k.	______________________
f.	______________________	l.	______________________

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application.

F. Additional Comments Section:

Section   Question #   Explanation/Comments

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G. Agreement and Authorization:

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 does not bind the MMA to complete the insurance, but that it is agreed that this form shall be the basis of the contract should the policy be issued and shall be considered a part of my insurance policy with the South Carolina Medical Malpractice Association.

____ _____ / _____ / _____

Signature of Applicant (Authorized Representative) Date

____

Title

Agent/Broker <u>must</u> 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.