South Carolina Medical Malpractice Association

550 South Main Street, Suite 525, Greenville, SC 29601
864-240-5449 *main* **864-240-2750** *fax*

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

MIDLEVEL SHARED LIMITS ENDORSEMENT REQUEST FORM

Instructions:

To add midlevel shared limits to your policy, please:
1. Complete, sign and date this form.
2. Scan/email to Admin.SCMMA@marsh.com

NOTE: Midlevels may be covered under a preceptor physician's policy.
Nurse Practitioners, Nurse Anesthetists, and Physician Assistants may have the option to be covered under the preceptor physician's policy in lieu of carrying a separate policy. By eliminating the separate policy for the midlevel you can save 75%. Each such midlevel employee shall not have his/her own limits of liability, but shall share in the limits of liability of the physician.

TO:

Admin.SCMMA@marsh.com MMA Underwriting Department

_____

FROM:

_____ Date: _____ / _____ / _____
Authorized Practice Representative Name

PRACTICE NAME: _____

PRECEPTOR PHYSICIANS NAME: _____

Phone:_____

Email:_____ Total # of Pages: _____

A. INSURED INFORMATION AND SHARED LIMITS COVERAGE REQUEST:

1. Preceptor Physician's Name: _____
2. Preceptor Physician's MMA Policy #:_____
3. Effective Date for this Change (M/D/Y): _____ / _____ / _____
4. Please add the following Midlevel as an Additional Insured to my policy:

   ◯ *Nurse Practitioner* ◯ *Physician Assistant* ◯ *CRNA*

   5a. Name: _____

5. Please discontinue the aforementioned midlevel's separate individual policy: (If applicable)

   5a. MMA Policy #:_____

6. Please check your preferred MMA limits of liability:

   ☐ $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

7. _____ *Initial Here* I understand that there is an additional premium for adding a midlevel to my policy.
   I understand that I will not have separate limits for my midlevel, and that if my entity is also an additional insured under my policy, my midlevel, my entity and I will share in the limits of liability under my MMA coverage.

B. 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 Physician Date

I understand that my coverage is only applicable while working for this physician's practice group and will not provide coverage for any outside moonlighting job/activity.

_____ _____ / _____ / _____
Signature of Midlevel Date