South Carolina Medical Malpractice Association

550 South Main Street, Suite 525, Greenville, SC 29601 – *corporate office*

864.240.5449 *main* 864-240-2750 *fax*

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

SC | MMA

PART TIME HEALTHCARE PROVIDER CREDIT APPLICATION

Instructions:

1. Complete, sign and date this form then scan/email to Admin.SCMMA@marsh.com
2. Name of practice contact person requested in question 9 should be the appropriate person for the SCMMA to contact regarding records.

Important:

- A Part Time Healthcare Provider Credit Application must be completed by the applicant every year for the purpose of determining whether the applicant is eligible for this type of coverage.
- The hours reported to the SCMMA are for rating purposes and are subject to audit at the SCMMA's discretion.
- Providers who are subject to experience rating are not eligible for this part time discount.

TO: Admin.SCMMA@marsh.com

Attn:

____

FROM:

____ Date: _____ / _____ / _____

Authorized Practice Representative Name

PRACTICE NAME: ____

APPLICANT'S NAME: ____

Phone:____

Email address: ____ Total # of Pages: ___________

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A. Personal Data for Applicant:

1. Applicant name: ______________________________

   1a. Billing address: ______________________________

   City: ______________________ State: ______________ Zip: __________

2. Individual requesting part time coverage is: ☐ Physician ☐ Dentist/Oral Surgeon ☐ Midlevel

   2a. If "**Midlevel**", please provide name of preceptor: ______________________________

3. Are you requesting part time credit due to reduced hours at your primary practice? ☐ Yes ☐ No

4. Are you requesting part time coverage for moonlighting or part-time work outside your primary practice? ☐ Yes ☐ No

   If "yes" please describe:

5. Applicant policy information:

   5a. MMA Policy # ____________________

   5b. Desired Policy Limits: ☐ $1M/$3M ☐ $1.2M/$3.6M ☐ $2M/$4M or ☐ $3M/$6M

6. Part time practice name: ______________________________

7. Part time practice address. Where do you work?

   Street Address: ______________________________

   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: ______________________

11 Applicant email: ______________________ 11a. May we contact you by email? ☐ Yes ☐ No

12. Describe scope of part time practice: ______________________________

13. Effective date of part time discount: _____ / _____ / _____

14. Hours worked per month: ☐ 0-21 hours per month ☐ 22-43 hours per month ☐ 44-85 hours per month

15. Are you employed full-time or part-time at any other facility? ☐ Yes ☐ No

    15a. If "**Yes**", provide the name of employer: ______________________, and hours worked per month: ______

    15b. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No

    15c. If "**Yes**", please provide the name of carrier: ______________________________

16. List hospitals where you currently hold privileges: ______________________________

    ____

B. 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 shall be considered a part of the terms and conditions of my insurance policy with the *South Carolina Medical Malpractice Association*.

______________________________ _____ / _____ / _____

Signature of Applicant Date

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