South Carolina Medical Malpractice Association

550 South Main Street – Suite 525, Greenville, SC 29601 *corporate office*
864.240.5449 *main* **866.893.6270** *toll free* **864.240.2750** *fax*
www.scmma.net

PRACTICE ENTITY 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 / broker.
4. Please submit the completed application form, along with required attachments and any additional information to the applicant's insurance agent / 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 **business letterhead**.

4. ☐ **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.

B. AGENT/BROKER INFORMATION

5. 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.

Agency 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			
	Endorsements				Final Premium	

C. PRACTICE LOCATION AND GENERAL INFORMATION

6. The precise name of the applicant/practice entity*:

   Name: _____ Federal Tax ID #: _____

   * *Practice / Professional Association/Corporate name. Please list names of all other entities to be insured in the Additional Comments Section of this application.*

7. Preferred Billing Address (Your invoice will be mailed to this address.)

   P.O. Box or Street: _____ Suite #:_____

   City: _____ State: _____ Zip: _____

8. Primary Practice Address:

   Street Address 1: _____

   Street Address 2: _____

   City: _____ State: _____ Zip: _____

9. Office Telephone #: _____ 9a. Fax #: _____

   9b. May we contact you by fax? ☐ Yes ☐ No

10. Contact Name: _____ 10a. Contact Title: _____

11. Contact Email Address: _____ 11a. May we contact you by email? ☐ Yes ☐ No

12. Practice Entity Web Address: _____

13. Secondary Practice Address:

   Street Address 1: _____ Suite #:_____

   Street Address 2: _____

   City: _____ State: _____ Zip: _____

14. Office Telephone #: _____ 14a. Fax #: _____

15. Do you have additional office locations not listed above? ☐ Yes ☐ No
   *15a. If "**Yes**", list additional offices in Additional Comments Section*

Important: 80% of your practice must be in South Carolina. Up to 20% of your practice may be across state lines. 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.

D. COVERAGE SELECTION INFORMATION

IMPORTANT: *SC MMA offers limits of liability of $1,000,000 EACH MEDICAL INCIDENT / $3,000,000 ANNUAL AGGREGATE for Practice Entity policies.*

16. Has applicant been insured by the SCMMA/SCJUA before: ☐ Yes ☐ No
    16a. If "Yes": Prior policy #:_____ 16b. Dates of coverage (M/Y): _____ / _____ - _____ / _____

17. This application is for a: ☐ New Policy ☐ Re-write ☐ Renewal

18. Please indicate the type of coverage you are applying for:
    18a. ☐ **Occurrence coverage**
    18b. ☐ **Claims-made** coverage **WITHOUT** prior acts coverage
    If selecting 18b, please select one of the following:
    18bi. ☐ 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.
    18bii. ☐ My current policy is on an occurrence form, therefore *Prior Acts Coverage* is not applicable.
    18c. ☐ **Claims-made** coverage **WITH** prior acts coverage (subject to restrictions and underwriting approval)
    If selecting 18c, please complete the following:
    18ci. Requested prior acts date (M/D/Y): _____ / _____ / _____
    This date cannot be prior to the retroactive date shown on your current policy.

19. **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.

20. **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.

E. RATING INFORMATION

21. Please list below the names of all physicians/dentists/podiatrists/optometrists and pharmacists who are associated with applicant 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
a.	_____	_____	☐	☐	☐ Y ☐ N
b.	_____	_____	☐	☐	☐ Y ☐ N
c.	_____	_____	☐	☐	☐ Y ☐ N
d.	_____	_____	☐	☐	☐ Y ☐ N
e.	_____	_____	☐	☐	☐ Y ☐ N
f.	_____	_____	☐	☐	☐ Y ☐ N

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 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.*

F. Other Professional Employees/Independent Contractors:

22. 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?

a.	Technician – Radiation Therapy	☐ Yes	☐ No	How Many? _____
b.	Technician – (x-ray, nuclear, path, sono, other)	☐ Yes	☐ No	How Many? _____
c.	Surgical Technician	☐ Yes	☐ No	How Many? _____
d.	Physician Assistant	☐ Yes	☐ No	How Many? _____
e.	Nurse Practitioner	☐ Yes	☐ No	How Many? _____
f.	Nurse Midwife	☐ Yes	☐ No	How Many? _____
g.	Anesthesiologist	☐ Yes	☐ No	How Many? _____
h.	Nurse Anesthetist / Anesthesia Assistant	☐ Yes	☐ No	How Many? _____
i.	Licensed Therapist or Psychologist	☐ Yes	☐ No	How Many? _____
j.	Licensed Estheticians	☐ Yes	☐ No	How Many? _____

k. Other (Please specify) _____

22a. **IMPORTANT**: *If you answered "Yes" to "d" through "j", please list the individual's names, specialty, carrier, policy number, and 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.

G. Employees as Additional Insureds Endorsement – "Staff Coverage":

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 practice. 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.

23. 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.

H. ORGANIZATIONAL INFORMATION

24. Entity Type:

- ☐ Professional Association
- ☐ Multi-Shareholder Corporation, Partnership, LLC
- ☐ Solo Incorporated – No employed or contracted physicians
- ☐ Hospital Owned
- ☐ Government Owned
- ☐ Industrial
- ☐ Other: _____

25. Is the purpose of the entity other than a medical or dental office practice? ☐ Yes ☐ No
    25a. If **"Yes"**, please explain in the *Additional Comments Section.*

26. Do you have any office or expense sharing arrangements with any other physician(s) or practice group(s)? ☐ Yes ☐ No
    26a. If **"Yes"**, please explain in the *Additional Comments Section*.

27. Do you own or operate a surgery center, laboratory or other outpatient facility? ☐ Yes ☐ No
    27a. If **"Yes"**, do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    27b. If **"Yes"**, please explain in the *Additional Comments Section*.

28. Do you participate in pharmaceutical testing programs/clinical investigation studies? ☐ Yes ☐ No
    28a. If **"Yes"**, do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    28b. If **"Yes"**, please explain in the *Additional Comments Section*.

29. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
    29a. If **"Yes",** do you see these patients in (check all that apply):
    - ☐ your office,
    - ☐ a correctional facility?

30. 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
    30a. If **"Yes",** please explain in the *Additional Information Section*.

31. 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
    31a. If **"Yes"**, please explain in the *Additional Comments Section*.

32. Are you in any way affiliated with a medical spa or weight loss facility? ☐ Yes ☐ No
    32a. If **"Yes"**, please explain in the *Additional Comments Section*.

I. PROFESSIONAL LIABILITY INSURANCE HISTORY:

33. Has your practice ever operated without professional liability coverage? ☐ Yes ☐ No

34. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage (tail coverage)? ☐ NA ☐ Yes ☐ No

35. 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

36. If questions 33-35 are answered "**Yes**", please provide a detailed description in *Additional Comments Section.*

37. If prior carrier was **not** the SC MMA, 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

J. CLAIMS INFORMATION

Important: The words "claim" and "circumstance" as used in Questions 38 and 39 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 records or expressing dissatisfaction regarding your medical 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 38a*iii on the following page.*

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

38a. 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*) _____

38b. If "**Yes"**, have all been reported to your current or prior professional liability insurer? ☐ NA ☐ Yes ☐ No

39. Other than the claims/suits indicated in question 38 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

39a. If "**Yes"**, how many? _____ (*Please attach details of each circumstance*.)

39b. If "**Yes"**, have all been reported to your current or prior professional liability insurer? ☐ NA ☐ Yes ☐ No

39c. If all have **not** been reported to your current or prior professional liability insurer, please explain in *Additional Comments Section* or on separate sheet.

40. 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 during the delivery 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

K. 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 38 and 39 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 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:

_____

_____

_____

_____

_____

L. ADDITIONAL COMMENTS SECTION:

Section Question # Explanation/Comments

M. 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 (Authorized Representative) Date

_____
Title

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