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**

PRACTICE ENTITY APPLICATION – RENEWAL SHORT FORM

Assessable Policy

Instructions:

1. Please answer ALL questions completely, leaving no blanks. (Use N/A if Not Applicable)
   Then scan/email to Admin.SCMMA@marsh.com
2. If you need more space for responses, 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.
4. Please submit the completed application, along with a copy of the insured practice's business letterhead and any other required additional information.
5. Please contact the *SCMMA Underwriting Department* if you have any questions.

A. Policy Information:

Important: *The SCMMA offers limits of liability of $1,000,000 EACH MEDICAL INCIDENT / $3,000,000 ANNUAL AGGREGATE for Practice Entity policies.*

1. Current Policy #: ______________________ 1a. Expiration Date: _____ / _____ / ____

2. Policy Type: (Check all that apply) ☐ Occurrence ☐ Claims Made ☐ Separate Policy ☐ Entity Shared Limits Endorsement

B. General Information:

3. The precise name of the insured practice entity:

   Name: ____ Federal ID #____________________

   3a. List names of all other entities to be insured (if applicable) in the *Additional Comments Section* of this application.

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

   P.O. Box or Street: ____

   City: ______________________ State: ______________________ Zip: __________

5. Practice Address:

   Street Address 1: ____

   Street Address 2: ____

   City: ______________________ State: ______________________ Zip: __________

6. Do you have additional office locations not listed above? ☐ Yes ☐ No

   6a. If "**Yes**", please list additional offices in *Additional Comments Section.*

7. Office Telephone Number: ______________________ 7a. Fax Number: ______________________

   7a. May we contact you by fax? ☐ Yes ☐ No

8. Contact Name: ______________________ 8a. Contact Title: ______________________

9. Contact Email Address: ______________________ 9a. May we contact you by email? ☐ Yes ☐ No

10. Practice Entity Web Address: ____

C. Physicians / Dentists / Podiatrists / Optometrists / Pharmacists:

11. Please list below the names of all physicians/dentists/podiatrists/optometrists and pharmacists who are associated with your 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.*

D. Other Professional Employees/Independent Contractors:

12. 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): ____

12a. ***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 No.	Limits
______________	______________	______________	__________	__________
______________	______________	______________	__________	__________
______________	______________	______________	__________	__________

If more space is needed, continue on a separate sheet. Please inform the MMA of any changes as they occur.

E. Employees as Additional Insureds Endorsement - "Staff Coverage":

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 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.

13. 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.

F. Organizational Information:

14. Entity Type: Please check any that apply.

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

15. Is the purpose of the entity other than a medical or dental office practice? ☐ Yes ☐ No
15a. If **"Yes"**, please explain in the *Additional Comments Section.*

16. Do you have any office or expense sharing arrangements with any other physician(s) or practice group(s)? ☐ Yes ☐ No
16a. If **"Yes"**, please explain in the *Additional Comments Section*.

17. Do you own or operate a surgery center, laboratory or other outpatient facility? ☐ Yes ☐ No
17a. If **"Yes"**, do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
17b. If **"Yes"**, please explain in the *Additional Comments Section*.

18. Do you participate in pharmaceutical testing programs/clinical investigation studies? ☐ Yes ☐ No
18a. If **"Yes"**, do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
18b. If **"Yes"**, please explain in the *Additional Comments Section*.

19. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
19a. If **"Yes"**, do you see these patients in (check all that apply):

☐ your office,
☐ a correctional facility?

20. 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
20a. If **"Yes"**, please explain in the *Additional Comments Section*.

21. Are you in any way affiliated with a medical spa or weight loss facility? ☐ Yes ☐ No
21a. If **"Yes"**, please explain in the *Additional Comments Section*.

G. Broker Information:

22. Agency Name: ______________________________

Street Address 1: ______________________________

Street Address 2: ______________________________

City: ______________________ State: ______________ Zip: __________

Agency Contact Person: ______________________________

Agency Contact E-mail: ______________________________

H. Territory:

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.*

I. Additional Comments Section:

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If more space is needed, please continue on a separate sheet.

J. Agreement:

Signing this application does not commit the *MMA* to bind 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

____

Insured Practice Entity Name

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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 us immediately by telephone and return the original message to us via the U.S. Postal Service. Thank you.