SOUTH CAROLINA | JUA *the medical liability experts*

South Carolina Joint Underwriting Association
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ADDITIONAL INSURED – VICARIOUS LIABILITY ENDORSEMENT REQUEST FORM

Instructions

1. Please read Section "B" carefully, and call the JUA if you have questions.
2. Please answer ALL questions, leaving no blanks.
3. If more space is needed for responses, please continue on a separate sheet with the question # noted.
4. The endorsement request must be signed and dated by the Insured
5. Please fax the completed form, along with any attachments (i.e. expanded responses per # 3, above) to the SCJUA and the SCPCF. You may use this page as a fax coversheet.
   JUA Underwriting Department Fax #: 864-240-2750
   PCF Underwriting Department Fax #: 803-896-5294

A. FAX COVER INFORMATION:

TO:
JUA Underwriting Department
Fax # 864-240-2750
PCF Underwriting Department
Fax # 803-896-5294

_____

FROM:

_____ Date: _____ / _____ / _____
Insured or Authorized Representative of Insured (Printed)

NAME OF HEALTHCARE FACILITY/ENTITY TO BE LISTED AS ADDITIONAL INSURED FOR VICARIOUS LIABILITY ONLY:

_____

INDIVIDUAL INSURED'S NAME: _____

Phone:_____

Fax: _____ Total # of Pages: _____

The information contained in this transmission is privileged and confidential. It is intended only for the use of the JUA. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this transmission is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone and return the original message to the South Carolina JUA via the U.S. Postal Service. Thank you.

B. ADDITIONAL INSURED – VICARIOUS LIABILITY ENDORSEMENT OPTION:

The individual insured may choose to include the listed Healthcare Facility / Entity as an Additional Insured for Vicarious Liability by adding the Additional Insured - Vicarious Liability Endorsement to their policy. There is no additional charge for this endorsement. The listed Healthcare Facility / Entity specifically named in the Declarations as an Additional Insured shall neither have its own limit of liability, nor separate coverage, but shall merely be covered for any vicarious liability arising out of the acts or omissions of the Named Insured (the individual), subject to the terms and conditions of the policy issued, to which this endorsement is attached. Coverage for listed Healthcare Facility / Entity ceases upon the termination of the policy issued to the Named Insured (the individual). If the policy to which this endorsement is attached is issued on a claims-made basis and is cancelled or non-renewed, except if for non-payment of premium, the Named Insured (the individual) or the listed Healthcare Facility / Entity may exercise the option to purchase the Extended Reporting Period Endorsement ("tail coverage").

C. INSURED INFORMATION AND COVERAGE REQUEST:

1. Individual Insured's Name: _____
2. Individual Insured's JUA Policy # : _____ 2a. Individual Insured's PCF Member ID #: _____
3. Effective Date for this Change (M/D/Y): _____ / _____ / _____
4. Name of listed Healthcare Facility / Entity to be added as an Additional Insured for Vicarious Liability Only:

   _____

5. Please add the Additional Insured - Vicarious Liability Endorsement to my policy naming the aforementioned **Healthcare Facility / Entity** as an Additional Insured.

   _____ ***Initial Here*** ***Important****: I understand that my individual JUA policy limits are 200,000/600,000 and that the PCF individual policy limits are inclusive of the JUA basic limits. Example: The PCF limit of $1Million/$3Million is actually $800,000 excess of the $200,000 JUA basic limits per incident/ and $2,400,000 excess of the $600,000 annual aggregate. I understand that there will not be separate limits or coverage for listed Healthcare Facility/Entity; but that the listed Healthcare Facility/Entity shall merely be covered for any vicarious liability arising out of the acts or omissions of the Named Insured (the individual), subject to the terms and conditions of the policy issued, to which this endorsement is attached.*

6. Please check the appropriate limits of liability you would like from the South Carolina PCF. For details on PCF rates please contact the South Carolina Patients' Compensation Fund @ 803-896-5290.

   ☐ $1,000,000 per claim/ $3,000,000 annual aggregate

   ☐ $2,000,000 per claim/ $4,000,000 annual aggregate

   ☐ $3,000,000 per claim/ $6,000,000 annual aggregate

   ☐ $5,000,000 per claim/ $7,000,000 annual aggregate

   ☐ $10,000,000 per claim/ $12,000,000 annual aggregate

D. 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 Insured Date

Acknowledgement of the listed Healthcare Facility / Entity:

_____ _____ / _____ / _____
Signature of Authorized Representative Date

_____
Printed Name of Authorized Representative / Title