SOUTH CAROLINA | MMA
SOUTH CAROLINA MEDICAL MALPRACTICE ASSOCIATION

the medical liability experts

South Carolina Medical Malpractice Association
550 South Main Street, Suite 525, Greenville, SC 29601 *corporate office*
Lock Box 93523, Atlanta, GA 31193-2523 *payment remittance address*
864.240.5449 main 866.893.6270 *toll-free* 864.240.2750 *fax*
www.scmma.net

The South Carolina MMA *is a not-for-profit association established to insure, support and defend South Carolina medical professionals. The association is managed by Marsh USA, Inc.*

ADDITIONAL INSURED – VICARIOUS LIABILITY ENDORSEMENT REQUEST FORM

Instructions

1. Please read Section "B" carefully, and call the MMA 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 SCMMA Underwriting Department Fax #: 864-240-2750.

A. FAX COVER INFORMATION:

TO:
MMA Underwriting Department
Fax # 864-240-2750

FROM:

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

Phone:_____

Fax: _____ Total # of Pages: _____

The information contained in this transmission 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 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 MMA via the U.S. Postal Service. Thank you.

A. 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 not 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 the 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").

B. Insured Information and Coverage Request:

1. Individual Insured's Name: _____
2. Individual Insured's MMA Policy Number: _____
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** I understand that there will not be separate limits or coverage for the 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 confirm the policy limits of liability you desire:
   - ◯ $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
   - ◯ $5,000,000 each Medical Incident / $7,000,000 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