

# 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](http://www.scmma.net)

## SC | MMA

### PART TIME HEALTHCARE PROVIDER CREDIT APPLICATION

Instructions:

1. Sign and date this form and fax to the SCMMA. You may use this page as a fax coversheet.
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 purposes 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.

**A. FAX COVER INFORMATION:**

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**TO:** SCMMA Underwriting Department – Attn: Samantha Day  
Fax # 864-240-2750

\_\_\_\_\_

**FROM:**

\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Authorized Practice Representative Name

**PRACTICE NAME:** \_\_\_\_\_

**APPLICANT'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 SCMMA. 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 Medical Malpractice Association via the U.S. Postal Service. Thank you.

**B. 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. If Available: Former JUA Policy # \_\_\_\_\_ Former PCF Member # \_\_\_\_\_  
 5b. Desired Policy Limits:  \$1M/\$3M  \$2M/\$4M  \$3M/\$6M or  \$5M/\$7M
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: \_\_\_\_\_  
 \_\_\_\_\_

**C. 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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