South Carolina Medical Malpractice Association

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www.scmma.net

SC | MMA
PHYSICIAN 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 or broker.
4. Please submit the completed application form, along with required attachments and any additional requested information to the applicant's insurance agent or 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 **Curriculum Vitae** (CV/resume).
4. ☐ Copy of **business letterhead**.
5. ☐ **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.
6. ☐ **National Practitioner Databank Report** (http://www.npdb.hrsa.gov or 1-800-767-6732). The evaluation or date of issue of such loss runs may not be more than 60 days old.

B. Agent/Broker Information:

7. 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.

Agent/Broker 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		Policy Fee	
	Endorsements				Final Premium	

C. Personal Information:

8. Full name of applicant: First ______________________ Middle ______________ Last: ________________
9. Gender: ☐ Male ☐ Female 9a. Date of birth (M/D/Y): _____ / _____ / _____
10. Professional Designation: ☐ M.D. ☐ D.O.
11. Home Address:
    Street: ____ Apt. / Unit #: __________
    City: ____________________________ State: __________________ Zip: __________
12. Telephone #: ______________________ 12a.Fax #: ________________________
13. Email address: ____
14. May we contact you by e-mail: ☐ Yes ☐ No 14a. May we contact you by fax? ☐ Yes ☐ No

D. Practice Location(s) and Contact Information:

Purpose for MMA Policy *(practice entity where you will be using the MMA policy for coverage):*

15. The precise name of applicant's practice entity:
    Name: ____
16. Primary practice physical address:
    Street: ____ Suite / Unit #: __________
    City: ____________________________ State: __________________ Zip: __________
17. Telephone #: ______________________ 17a. Fax #: ________________________
18. Primary practice email address: ____
19. May we contact you by e-mail: ☐ Yes ☐ No 19a. May we contact you by fax? ☐ Yes ☐ No
20. Practice Entity Web Address: ____

Secondary Practice Location *(will you be using the MMA policy for coverage at this location also?* ☐Yes ☐No)

21. The precise name of applicant's secondary practice entity:
    Name: ____
22. Secondary practice physical address:
    Street: ____ Apt. / Unit #: __________
    City: ____________________________ State: __________________ Zip: __________
23. Telephone #: ______________________ 23a. Fax #: ________________________
24. Practice Entity Web Address: ____
25: Preferred Billing Address: ☐ Home ☐ Primary office ☐ Secondary office ☐ Other
    25a. If "**Other**", please provide address: ____
26. Do you have additional practice locations not listed above where you will be using the MMA policy for coverage? ☐ Yes ☐ No
    26a. If "**Yes**", list additional office locations in the *Additional Comments Section* of this application or on a separate sheet.

E. Physician Coverage Selection:

Important:

SC MMA offers Physicians a range of limits to choose from. Please <u>select</u> and <u>initial</u> in the blank your choice of limits below.

☐ *$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* ______________

27. Have you been insured by the SCMMA or the SCJUA before: ☐ Yes ☐ No
    27a. If "Yes": Prior policy #: ______________________ 27b. Dates of coverage (M/Y): _____ / _____ - _____ / _____

28. Is this application for a: ☐ New Policy ☐ Re-write ☐ Renewal

29. Please indicate the type of coverage you are applying for:
    29a. ☐ **Occurrence coverage**
    29b. ☐ **Claims-made** coverage **WITHOUT** prior acts coverage
    If selecting 29b, please select one of the following:
    29bi. ☐ 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.*
    29bii. ☐ My current policy is on an occurrence form; therefore, *Prior Acts Coverage* is not applicable.
    29c. ☐ **Claims-made** coverage **WITH** prior acts coverage (subject to restrictions and underwriting approval)
    If selecting 29c, please complete the following:
    29ci. Requested prior acts date (M/D/Y): _____ / _____ / _____
    This date cannot be prior to the retroactive date shown on your current policy.

30. **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.

31. **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.

F. Rating Information:

32. What is your present specialty? ________________________________ Percentage of Practice? _______%

33. What is your present sub-specialty? ________________________________ Percentage of Practice? _______%

34. Are you American Board Certified? ☐ Yes ☐ No
    34a. If "**Yes**": Specialty Board ________________________________
    34b. If "**Yes**": Date Certified: ____ / ____ / ____
    34c. If "**No**": are you board eligible? ☐ Yes ☐ No
    34d. If not board eligible, provide explanation in the *Additional Comments Section.*

35. Have you ever failed any licensing or Board Certification or recertification examination? ☐ Yes ☐ No
    35a. If "**Yes**", provide name(s) of exam(s) and number of times failed in the *Additional Comments Section.*

36. Have there been any changes in your specialty, classification, or practice activity within the past five years? ☐ Yes ☐ No
    36a. If "**Yes**", describe the nature of the change(s) in the *Additional Comments Section.*

37. Have you discontinued performing minor or major surgical procedures, or OB procedures within the past five years? ☐ Yes ☐ No
    37a. If "**Yes**", list the procedure(s) in the *Additional Comments Section.*

38. Do you, or will you, staff an emergency room? ☐ Yes ☐ No
   38a. If **"Yes"**, how many hours per week? ____
   38b. If **"Yes"**, do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
   38c. If **"Yes"**, provide details in the *Additional Comments Section* and attach verification of coverage.

39. Are you an EMS control physician? ☐ Yes ☐ No
   39a. If **"Yes"**: ☐ Online, or ☐ Offline
   39b. If **"Yes"**, where? ____

40. If you perform obstetrical procedures, do you have privileges to perform C-sections at each hospital you staff? ☐ NA ☐ Yes ☐ No
   40a. Average number of deliveries per year: _____
   40b. Percentage of high risk deliveries _____ % and,
   40c. Average number of VBAC deliveries per year: _____

41. Do you perform surgical procedures using nurse anesthetists to administer anesthesia who are not directed by/responsible to an anesthesiologist? ☐ NA ☐ Yes ☐ No
   41a. If **"Yes"**, please explain in the *Additional Comments Section*.

42. Will you read your own X-rays? ☐ Yes ☐ No
   42a. If **"Yes"**, will they subsequently be read by a radiologist? ☐ Yes ☐ No
   42b. If **"Yes"**, how soon? Within _________ hours.

43. Do you practice any of the following forms of "Alternative Medicine" including Ayurvedic Medicine, Chiropractic Medicine, Holistic Medicine, Homeopathic Medicine, and/or Naturopathic Medicine? ☐ Yes ☐ No
   43a. If **"Yes"**, please explain in the *Additional Comments Section*.

44. Do you perform? (Check all boxes that apply)

   ☐ **OBSTETRICS** – Any pre-natal care after the first trimester, deliveries, and C-sections.

   ☐ **MAJOR SURGERY** – Operations or supervising of operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life. For example: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation done using general anesthesia. Tonsillectomies, adenoidectomies shall be considered major surgery.

   ☐ **MINOR SURGERY** – All other invasive, diagnostic, and surgical procedures not constituting major surgery including vasectomies, circumcisions, and radiopaque dye injections, needle biopsy of lung or prostate, colonoscopies, and EGD procedures. Incision of boils and superficial abscesses or suturing of skin or superficial fascia are not considered minor surgery for purposes of this application.

   ☐ **NO SURGERY** – No invasive or surgical procedures other than: incision of boils, superficial abscesses, suturing of skin or superficial fascia and punch biopsies. Newborn circumcisions performed by pediatricians and family physicians.

45. Do you assist in Major Surgery? ☐ Yes ☐ No
   45a. If **"Yes"**, ☐ own patients only ☐ on patients of others.
   45b: If **"Yes"**, please describe what types of major surgery: ____

   ____

   ____

46. Do you perform any surgery in your office? ☐ Yes ☐ No
   46a. If **"Yes"**, please describe what types of surgery: ____

   ____

   ____

47. Please check any of the following that applies:

Please contact the MMA at 864-240-5449 if you have any questions regarding your performance of procedures within the following classifications. Failure to properly complete question #47 may impair your coverage.

- ☐ Elective Abortions
  - ☐ Prescribe Preven, or related derivatives
  - ☐ Prescribe Mifepristone, or related derivatives in combination with cytotec
- ☐ Acupuncture
- ☐ Anesthesia
  - ☐ Spinal
  - ☐ Caudal
  - ☐ General
  - ☐ Local
  - ☐ Conscious Sedation
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
  - ☐ On Own patients
  - ☐ On Patients of Others
- ☐ Bariatric surgery
- ☐ Biopsy
  - ☐ Breast Biopsy
  - ☐ Kidney Biopsy
  - ☐ Lung Biopsy
  - ☐ Prostate Biopsy
- ☐ Blepharoplasty
- ☐ Breast Implants
  - ☐ Cosmetic
    - ________% of practice
  - ☐ Reconstructive
    - ________% of practice
- ☐ Bronchoscopy
- ☐ Cardiac – major surgery
- ☐ Cardiovascular disease – major surgery
- ☐ Chelation therapy (<u>is excluded under this policy</u>)
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Cholecystectomy, Laparoscopic
- ☐ Circumcision (other than newborns)
- ☐ Colon and rectal-major surgery
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Critical Care Specialist
- ☐ Cryosurgery (other than external lesions)
- ☐ Dermatological Surgery/Other Procedures
  - ☐ Botox
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Collagen Injections
  - ☐ Cryosurgery (superficial only)
  - ☐ Dermabrasion
  - ☐ Eye liner pigmentation
  - ☐ Fat Transfer
  - ☐ Hair transplants
  - ☐ Laser Hair Removal
  - ☐ Laser Skin Resurfacing
  - ☐ Microdermabrasion
  - ☐ Silicone Injections
  - ☐ Tumescent or Smart Liposuction
  - ☐ Mohs Surgery
  - ☐ Other: ____________________
- ☐ D&C
- ☐ Dermatopathology
- ☐ Echocardiography
- ☐ Electrocardiography
- ☐ Emergency medicine
- ☐ Encephalography
- ☐ Endoscopic Laser Therapy
- ☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy
- ☐ ERCP / EGD / ERC
- ☐ Exchange Transfusions in Newborns
  - How many per year? __________
- ☐ Fertility Treatment
- ☐ Fluoroscopy
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Gastroscopy
- ☐ General – major surgery
- ☐ Gynecology – major surgery
- ☐ Hand – major surgery
- ☐ Head and neck – major surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip nailings
- ☐ Hospitalist
- ☐ Hyperbaric Medicine
- ☐ Hysterectomy
- ☐ Hysteroscopy
- ☐ Intensivist
- ☐ Intensive care for newborns within a Tertiary Care Unit
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ Laryngology – major surgery
- ☐ Laser Surgery
- ☐ Left Heart Catheterization
- ☐ Liposuction
- ☐ Lithotripsy
- ☐ Lumbar Fusion
- ☐ Mammography
- ☐ Myelography
- ☐ Myomectomy
- ☐ Neonatology
- ☐ Neurology – major surgery
- ☐ Norplant Insertion/Extraction
- ☐ Obstetrics/Gynecology – major surgery
  - ☐ Normal deliveries
  - ☐ C-Sections
  - ☐ VBAC
  - By induction? ☐Y ☐N
  - Induction agent: ____________________
- ☐ Ophthalmology – major surgery
- ☐ Organ Transplant
- ☐ Orthopedic – major surgery
  - ☐ With Back & Spine
  - ☐ No Back & Spine
- ☐ Osteopathic manipulative medicine
- ☐ Otology – major surgery
- ☐ Otorhinolaryngology – major surgery
  - ☐ Including elective cosmetic procedures
  - ☐ Not including elective cosmetic procedures
- ☐ Pain Management
  - ☐ Medication Only
  - ☐ IDD Therapy
  - ☐ Facet Blocks
  - ☐ Selective Nerve Root Blocks
  - ☐ Rhizotomy
  - ☐ Spinal Injections
  - ☐ Dorsal Root Gangliotomies
  - ☐ Thoracic Sympathectomies
  - ☐ Spinal Cord Stimulators
  - ☐ Implantation/Removal of Drug Infused Pumps
  - ☐ Sphenopalatine Lesioning
  - ☐ Trigeminal Lesioning
  - ☐ Cordotomies
  - ☐ Other ______________
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Percutaneous vertebroplasty
- ☐ Permanent Pacemaker
- ☐ Plastic – major surgery
- ☐ Polypectomy
- ☐ Prenatal Care (Past 1st Trimester)
- ☐ Prolotherapy
- ☐ Radiation/X-ray Therapy
- ☐ Radiopaque Dye
- ☐ Rapid Opiate Detoxification
- ☐ Rhinology – major surgery
- ☐ Robotics utilized
- ☐ Roux-en-y
- ☐ Sclerotherapy
- ☐ Scoliosis Surgery
- ☐ Shock Therapy
- ☐ Sterilization procedures
- ☐ Thoracic surgery ______________%
- ☐ Thyroidectomy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Transgender surgery and/or hormonal gender conversion
- ☐ Trigger point injections
- ☐ Tubal ligation
- ☐ Urgent Care Medicine
- ☐ Urology – major surgery
- ☐ Vascular surgery ______________%
- ☐ Vasectomy
- ☐ Weight Control _________%
  - ☐ Bariatric Bypass
  - ☐ Gastric Bubble or Jejuno-Ileal Bypass
  - ☐ Gastric Stapling
  - ☐ Gastric Banding
  - ☐ Other
  - ☐ Medications Prescribed (please list):
    - ____________________
    - ____________________
    - ____________________
    - ____________________
- ☐ None of the above applies to my practice.
- ☐ Other Procedures (List):
  - ____________________
  - ____________________
  - ____________________
  - ____________________
  - ____________________

G. Practice Information:

48. Indicate the average weekly numbers under each of the following categories.
    48a. Number of scheduled patients seen per week: ____________
    48b. Number of walk-in patients seen per week: ____________
    48c. Number of hours worked per week: ____________

49 Are you applying for part time coverage? ☐ Yes ☐ No
    49a. If "**Yes**", please indicate the number hours worked per month: ____________
    49b. If "**Yes**", please provide name and contact information for individual the SC MMA may contact for audit of records:
    Name: ____________ Telephone #: ____________
    Address: ____________

    49c. Check one: ☐50% discount *(up to 21 hours per month)* ☐40% discount *(22-43 hours per month)* ☐30% discount *(44-85 hours per month)*

50. Are you permanently retired from the practice of clinical medicine? ☐ Yes ☐ No
51. Are you employed full-time or part-time by the Federal, State, or Local Government or are you in active duty in the military services? ☐ Yes ☐ No
    51a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    51b. If "**Yes**", provide details in the *Additional Comments Section* and note if coverage is provided by the Federal Tort Claims Act. Attach verification of coverage, if applicable.

52. Do you perform medical or surgical procedures at a surgery center, office-based surgical suite, or similar facility? ☐ Yes ☐ No
    52a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    52b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

53. Do you perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? ☐ Yes ☐ No
    53a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    53b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage.

54. Do you read, interpret or diagnose films, slides or specimens taken from patients who are receiving medical treatment in other states? ☐ Yes ☐ No
    54a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
    54b. If "**Yes**", provide details in the *Additional Comments Section,* and attach verification of coverage.

55. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
    55a. If "**Yes**", do you see these patients: (Please check one.) ☐ in your office, or ☐ at the correctional facility?

56. Do you provide clinical or administrative services to any nursing home, hospice, sanitarium, laboratory, spa or other facility or business enterprise? ☐ Yes ☐ No
    56a. If "**Yes**", do you serve as the Medical Director? ☐ NA ☐ Yes ☐ No
    56b. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    56c. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.
    56d. If "**No**", please be aware the SCMMA does not provide coverage for Medical Directors.

57. Do you participate in pharmaceutical testing programs/clinical investigation studies with drugs that are not FDA approved? ☐ Yes ☐ No
    57a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    57b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable, and copy of the indemnification agreement provided by the pharmaceutical company.

58. Do you own or operate a surgery center, facility, laboratory, or other outpatient facility? ☐ Yes ☐ No
    58a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ NA ☐ Yes ☐ No
    58b. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

59. Are you engaged in "moonlighting" activities or performing activities other than reported above which will be covered by another professional liability policy? ☐ Yes ☐ No
    59a. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage.

60. Are you a preceptor physician for any physician assistant, nurse practitioner, CRNA or nurse midwife who is not your employee? ☐ Yes ☐ No
    60a. If "**Yes**", provide details in the *Additional Comments Section* and attach verification of coverage.

H. Hospital Practice Information:

61. List each institution where you have admitting privileges and estimate the total number of patients admitted and surgeries performed within the past twelve (12) months: (Use *Additional Comments Section* if additional space is required)

	Institution Name	City and State	Phone Number	Type of Privileges*	Total number of admitted patients, surgeries and procedures performed within past 12 months	Percentage of total hospital based practice (column total to equal 100%)
61a.						
61b.						
61c.						
61d.						

**Types of Privileges: A = Active, CS = Courtesy, CN = Consulting*

I. Professional Information:

62. Please answer "Yes" or "No". If your answer is "Yes" to any of the questions in this section, please indicate the date and state (if applicable) where action occurred. Please give full details on the *Additional Comments Section*. Note: The question "number sequence" is intentionally different in this section of the application.

A. 1. Have you had a denial, restriction, suspension, probation, or revocation of privileges by a hospital or other health care facility? ☐ Yes ☐ No

If "**Yes**": Date: _____/_____/_____ State: ______________________

2. Have you entered into any consent agreement that has adversely affected your privileges with any formal committee of a hospital or other health care facility? ☐ Yes ☐ No

If "**Yes**": Date: _____/_____/_____ State: ______________________

3. Have you had a denial, restriction, suspension, probation, or revocation of your privileges to prescribe medications by the Drug Enforcement Administration? ☐ Yes ☐ No

If "**Yes**": Date: _____/_____/_____ State: ______________________

B. 1. Have you had a denial, restriction, suspension, probation, or revocation of your license to practice medicine by any State Licensing Board or been issued a public reprimand? ☐ Yes ☐ No

If "**Yes**": Date: _____/_____/_____ State: ______________________

2. Have you entered into a consent agreement related to your license with any State Licensing Board or any other medical review committee in your field of practice? ☐ Yes ☐ No

If **"Yes"**: Date: _____ / _____ / _____ State: ________________________

3. Have you been convicted of or pled guilty to any misdemeanor or driving under the influence (excluding minor traffic violations)? ☐ Yes ☐ No

If **"Yes"**: Date: _____ / _____ / _____ State: ________________________

4. Do you prescribe or administer substances that are not FDA approved, perform procedures that are considered experimental, or perform procedures for which you do not have appropriate training or are not board certified? ☐ Yes ☐ No

5. Have you had an injury, illness, or other event occur that may impair your ability to practice? ☐ Yes ☐ No

If "Yes": Date(s): _____ / _____ / _____

6. Have you been declined, non-renewed, or cancelled by an insurance carrier with cause (excluding market withdrawal)? ☐ Yes ☐ No

If "Yes": Date: _____ / _____ / _____ Insurance carrier: ____

7. Have you experienced a medical incident or alleged injury in which there is no reasonable defense and failed to report it to your insurance carrier within 30 days of the occurrence? ☐ Yes ☐ No
Date of incident/alleged injury: _____ / _____ / _____ Date reported: _____ / _____ / _____

Insurance carrier: ____

8. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any mental illness, including but not limited to depression? ☐ Yes ☐ No

If **"Yes"**, has a relapse occurred following your initial treatment? ☐ Yes ☐ No

C. 1. Have you been found by a court of law or State Licensing Board to have participated in any sexual misconduct with a patient? ☐ Yes ☐ No

If **"Yes"**: Date: _____ / _____ / _____ State: ________________________

2. Have you been convicted of or pled guilty to a felony, convicted of or pled guilty to a criminal offense for which one of the elements is fraud or misrepresentation, or have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment or sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? ☐ Yes ☐ No

If **"Yes"**: Date: _____ / _____ / _____ State: ________________________

Note: Answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.

3. Have you been accused of or been found to have altered health care records? ☐ Yes ☐ No

If **"Yes"**: Date: _____ / _____ / _____

J. MEDICAL TRAINING AND WORK HISTORY:

63. List all states where you are licensed to practice medicine and your license numbers: **Important**: 80% of your practice must be in South Carolina. We will allow 20% of your practice to be across the state line. 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.

	State	License Number	Status Code	Percentage (%) of Patients Seen, Examined or Treated in Each State.
63a.				
63b.				
63c.				

*Status Code - **A** = Active, I = Inactive, P = Pending, T = Temporary

64. Medical School Information:

	Name of Medical School(s) Attended	Location	Degree	Date Graduated
64a.				
64b.				

65. Residency Information:

Name of Hospital Where Residency Served		Location of Hospital Where Residency Served
Specialty and/or Department	Start Date and End Date	Was Program Completed? ☐ Yes ☐ No

66. Second Residency Information: (if applicable)

Name of Hospital Where Second Residency Served		Location of Hospital Where Residency Served
Specialty and/or Department	Start Date and End Date	Was Program Completed? ☐ Yes ☐ No

67 Fellowship Information

Name of Hospital Where Fellowship Served		Location of Hospital Where Fellowship Served
Specialty and/or Department	Start Date and End Date	Was Program Completed? ☐ Yes ☐ No

68. Work History:

List all locations (City and State) where you have practiced in the last five years. List most recent location first. Do not include training programs but include all moonlighting positions.	Start Date and End Date (m/y)

69. If you are a Foreign Medical School Graduate, are you certified by the Educational Council for Foreign Medical Graduates or have you completed the Fifth Pathway Program? ☐ NA ☐ Yes ☐ No
69a. If **"Yes",** attach a copy of Certificate.

70. Do you average at least 40 hours of Category I CME units every 2 calendar years in your specialty? ☐ Yes ☐ No

71. Are you entering private practice for the first time? ☐ Yes ☐ No

K. PROFESSIONAL LIABILITY INSURANCE HISTORY:

72. Have you ever practiced without professional liability coverage? ☐ Yes ☐ No

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

74. 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

75. If questions 72-74 are answered **"Yes"**, please provide a detailed description in *Additional Comments Section.*

76. If prior carrier was **not** the SC MMA or the SC JUA, 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

L. PRACTICE ORGANIZATION:

77. Please check the boxes under 77a and 77b that best describe your primary practice affiliation(s):

77a. **Employment Status**

☐ Employee
☐ Shareholder/partner
☐ Independent contractor
☐ Solo unincorporated/sole proprietor
☐ Intern/resident/fellow
☐ Other: ______________________

77b. **Entity Type**

☐ Professional association
☐ Multi-shareholder corporation, partnership, LLC
☐ Solo Incorporated – no employed or contracted physicians
☐ Hospital owned
☐ Government owned
☐ Industrial
☐ Other: ______________________

78. Name of primary practice/entity organization: ______________________

79. Is the purpose of the entity named in question #78 other than a medical office practice? ☐ Yes ☐ No

80. Do you have any office or expense sharing arrangements with any other physician(s) or practice group(s) practice group(s) not disclosed? ☐ Yes ☐ No

81. Are there any subsidiaries of this business entity that provide health care related services? ☐ Yes ☐ No
81a. If **"Yes"**, please list subsidiary name (s) and a brief description of services in *Additional Comments Section.*

82. Is the entity eligible to be licensed to provide medical professional services? ☐ NA ☐ Yes ☐ No
 82a. If **"Yes",** attach a copy of the license to the application.

83. Are you in any way affiliated with a Medical Spa or Weight Loss Facility? ☐ Yes ☐ No
 83a. If **"Yes",** please explain in the *Additional Comments Section*.

84. Please list below the names of all individuals who are owner physicians in your primary practice entity.

	NAME	SPECIALTY	MMA insured
84a.	______________________	______________	☐ Yes ☐ No
84b.	______________________	______________	☐ Yes ☐ No
84c.	______________________	______________	☐ Yes ☐ No

This is for purposes of cross referencing.

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.* Each partner, employed or contracted physician who desires SCMMA coverage is required to submit an individual application.

85. Does the applicant's primary practice entity (named in question #78) currently maintain professional liability coverage? ☐ Yes ☐ No
 85a. If **"Yes"**, is this coverage: ☐ Occurrence or ☐ Claims-Made?
 85b. If Claims-Made, what is the retroactive date used by the current carrier (M/D/Y): _____ / _____ / _____

86. Date of Incorporation (M/D/Y): _____ / _____ / _____

87. Corporate Tax Identification Number: ________________

88. Do you desire coverage for the business entity named in question #78 above? ☐ Yes ☐ No
 88a. If **"Yes"** do you wish to share your individual policy limits with this business entity? ☐ Yes ☐ No
 88b. If **"No"**, and separate limits are desired, you must purchase a separate practice entity policy.

89. **Do you wish to add the Employees as Additional Insureds Endorsement?** ☐ NA ☐ Yes ☐ No

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.

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.

M. PROFESSIONAL EMPLOYEES OR INDEPENDENT CONTRACTORS OF AN INDIVIDUAL PHYSICIAN:

Important: Complete this section only if you are the employer and you do not have a separate professional liability policy for your practice.

90. An employer may incur a legal responsibility for the actions of his/her employee(s) or independent contractors. Additional charges may be applied to the policy 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?

Note: Independent contractors are considered to be employees for underwriting purposes.

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) ______________________			

91. **Important**: If **"Yes"** to any of "d" – "j" above, please list the individual name(s), specialty, carrier, policy number and the limits of coverage in the space provided below. The practice entity policy form does NOT extend individual coverage to 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.

N. CLAIMS HISTORY:

Important: The words "claim" and "circumstance" as used in Questions 92 and 93 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* (Section O) for each case reported in 92a*iii on the following page.*

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

92a. 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)*	________

92b. If "**Yes**", have all been reported to your current or prior professional liability insurer? ☐ NA ☐ Yes ☐ No

93. Other than the claims/suits indicated in question 92 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

93a. If "**Yes**", how many? ________ (*Please attach details of each circumstance.*)

93b. If "**Yes**", have all been reported to your current or prior professional liability insurer? ☐ NA ☐ Yes ☐ No

93c. If all have **not** been reported to your current or prior professional liability insurer, please explain in *Additional Comments Section* or on separate sheet.

94. 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

O. 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 92 and 93 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:

____

____

____

____

____

P. Additional Comments Section:

Section	Question #	Explanation/Comments
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______

Q. NEW PHYSICIAN RISK MANAGEMENT DISCOUNT AGREEMENT AND AUTHORIZATION:

A. FIRST YEAR RISK MANAGEMENT DISCOUNT
(Physicians that are subject to experience rating / schedule rating are not eligible for this discount.)

_________ *Initial here if applicable*

I am beginning my first year of practice since the completion of my medical training, and I agree to qualify for a 25% first year premium reduction subject to a maximum $2,000 premium reduction by completing the SC MMA Risk Management Program sponsored by the SCHA during my first year of practice. This discount is in the form of an endorsement with a return premium credit issued upon completion of the SC MMA Risk Management program sponsored by the South Carolina Hospital Association. Please contact the SC MMA to obtain further information regarding when the risk management seminars will be held: 864-240-5449.

_________ Initial here

B. 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.

C. It is important to understand the difference between Occurrence Coverage and Claims-Made coverage.

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

_________ Initial here

D. 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.

____
Name of Applicant (*Please Print Legibly*)

____ ____/____/____
Signature of Applicant Date

Agent/Broker <u>must</u> 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

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