

***Physician Professional Liability
Insurance Application***

**South Carolina Medical Malpractice Liability Insurance
Joint Underwriting Association
Assessable Policy**



**For assistance, please contact Marsh, the Program Administrator, at:
864-240-5400**

**SCJUA
c/o Marsh USA Inc.
550 South Main Street, Suite 600
P. O. Box 128 (29602)
Greenville, SC 29601
Fax: 864-240-2750**

Return Completed Application to:

Broker Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax: _____

Contact Name: _____

E-mail: _____

Important: No action can be taken on this application until it is fully completed. "Fully completed" means you have answered all questions, provided separate explanations where necessary, signed and dated in the appropriate places, and attached the following documents:

New Business or Rewrite:

1. Copy of current declarations page showing type of policy form and current retroactive date; and,
2. Verification of or intent to obtain Reporting Coverage (tail) from current carrier; and,
3. Loss run from all previous Professional Liability insurers for not less than the prior 10 years, or since you first became licensed, whichever is greater. The evaluation or date of issue of such loss runs may not be more than sixty (60) days old; and, a National Practitioner Databank report. (www.npdb-hipdb-hrsa.gov or 1-800-767-6732)
4. Copy of Curriculum Vitae (CV); and, copy of business letterhead.
5. **Coverage is not bound until the JUA receives payment in full.**

For JUA Use Only	Rating Class		Other Charges		Policy Fee	
	Endorsements				Final Premium	

SECTION I - PERSONAL INFORMATION

A. Full Name of Applicant:

_____ M.D. Male
 First Middle Last D.O. Female

B. Home Address:

_____ County _____
 Number & Street Suite

 City State Zip

 () Telephone Number () Fax Number

C. Date of Birth (MDY): _____ D. Social Security Number (last 4 only): _____

E. May we communicate with you by e-mail? Yes No If "Yes", E-Mail Address: _____

SECTION II - PRACTICE LOCATION(S) INFORMATION

A. Primary Practice Address:

_____ County _____
 Number & Street Suite

 City State Zip

 () Telephone Number () Fax Number

B. Secondary Practice Address:

_____ County _____
 Number & Street Suite

 City State Zip

 () Telephone Number () Fax Number

C. Preferred Mailing Address: Home Primary Office Secondary Office

D. May we communicate with you by fax? Yes No

E. Do you have additional office locations not listed above? Yes No
 If "Yes", list in *Additional Comments Section*.

SECTION III - PHYSICIAN COVERAGE SELECTION INFORMATION

Important Note: SCJUA offers individual physician limits of liability of \$200,000 each Medical incident / \$600,000 annual aggregate. For additional coverage, please contact the SC Patients' Compensation Fund at 803-896-5290 or www.scpf.com

New Policy **Re-write** **Renewal** **Prior Policy #:** _____

A. Type:

- Occurrence Coverage
- Claims-Made Coverage without Prior Acts Coverage. (Check the one appropriate response below):
 - An Extended Reporting Endorsement (tail coverage) is automatic or will be purchased from my current carrier.
Note: if previously insured on a claims-made basis, failure to obtain an Extended Reporting Endorsement will leave you without complete coverage.
 - My current policy is on an occurrence form.
- Claims-Made Coverage with Prior Acts Coverage (This is subject to restrictions.)

Requested retroactive date (M/D/Y): _____ 12:01 a.m.
(This date cannot be greater than the retroactive date shown on your current policy.)

B. Effective Date: Requested Coverage Effective Date: (M/D/Y): _____ 12:01 a
(This date cannot be earlier than the expiration date of your current policy. Annual policy terms will begin and end on the same month and day.)

C. Expiration Date: _____

SECTION IV - RATING INFORMATION

A. What is your present specialty? _____ Percentage of Practice? _____%

B. What is your present sub-specialty? _____ Percentage of Practice? _____%

C. Are you American Board Certified? Yes No
If "Yes": _____

Specialty Board _____ Date Certified _____

If "No", are you board eligible? Yes No
If not board eligible, provide explanation in the *Additional Comments Section*.

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

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

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

- G. Do you, or will you, staff an emergency room? Yes No
 If “Yes”, how many hours per week? _____
 If “Yes”, do you have coverage under a separate policy for this exposure? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage.
- H. Are you an EMS control physician? Online or Offline Yes No
 If “Yes”, where? _____
- I. If you perform obstetrical procedures, do you have privileges to perform C-sections at each hospital you staff? NA Yes No
 No
 i. Average number of deliveries per year _____,
 ii. Percentage of high risk deliveries _____ %, and
 iii. Average number of VBAC deliveries per year _____.
- J. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by/responsible to an anesthesiologist? NA Yes No
 If “Yes”, please explain in the *Additional Comments Section*.
- K. Will you read your own X-rays? Yes No
 i. If “Yes”, will they subsequently be read by a radiologist? Yes No
 ii. If “Yes”, how soon? Within _____ hours.
- L. 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
 If “Yes”, please explain in the *Additional Comments Section*.

M. 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 and superficial abscesses or suturing of skin or superficial fascia. Newborn circumcisions performed by pediatricians and family physicians.

Do you assist in Major Surgery? Yes No If yes, own patients only on patients of others.

If yes, please describe what types of major surgery:

Do you perform any surgery in your office? Yes No If yes, please describe what types of surgery:

Please contact the JUA at 864-240-5400 if you have any questions regarding your performance of procedures within the above classifications. Failure to properly complete this section may impair your coverage.

N. Please check any of the following that apply to your practice:

- 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 (this is excluded under this policy)
- 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
 - Chemabrasion
 - Collagen Injections
 - Cryosurgery (superficial only)
 - Dermabrasion
 - Eye liner pigmentation
 - Fat Transfer
 - Hair transplants
 - Laser Hair Removal
 - Laser Skin Resurfacing
 - Microdermabrasion
 - Silicone Injections
 - Tumescant Liposuction
 - 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
- Otolaryngology – 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 Jejunio-Ileal Bypass
 - Gastric Stapling
 - Gastric Banding
 - Other
 - Medications Prescribed (please list): _____

None of the above apply to my practice. _____
(PLEASE INITIAL)

Other Procedures (List): _____

SECTION V - PRACTICE INFORMATION

A. List all states where you are licensed to practice medicine and your license numbers:

State	License Number	Status Code	% of Patients seen, examined or treated in each state

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

80% of your practice must be in South Carolina. 20% may be in border areas such as Rock Hill / Charlotte, North Augusta / Augusta or Hilton Head / Savannah. Incidental exposure in states other than border states must have prior approval by the JUA.

B. DEA License Number: _____ NA

C. Indicate the average weekly numbers, under each of the following categories

- i. Number of scheduled patients seen per week? _____
- ii. Number of walk-in patients seen per week? _____
- iii. Number of hours worked per week? _____

D. Are you permanently retired from the practice of clinical medicine? Yes No

E. 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?
 If "Yes", do you have coverage under a separate policy for this exposure? Yes No
 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.

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

G. 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
 If "Yes", do you have coverage under a separate policy for this exposure? Yes No
 If "Yes", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

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

I. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates, Yes No
 If "Yes", do you have coverage under a separate policy for this exposure? Yes No
 If "Yes", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

- J. Do you provide clinical or administrative services to any nursing home, hospice, sanitarium or similar facility? Yes No
 If “Yes”, do you serve as the Medical Director? Yes No
 If “Yes”, do you have coverage under a separate policy for this exposure? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.
- K. Do you participate in pharmaceutical testing programs/clinical investigation studies with drugs that are not FDA approved?
 If “Yes”, do you have coverage under a separate policy for this exposure? Yes No
 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. Yes No
- L. Do you own or operate a surgery center, facility, laboratory, or other outpatient facility? Yes No
 If “Yes”, do you have coverage under a separate policy for this exposure? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.
- M. Are you engaged in “moonlighting” activity or perform activities other than reported above which will be covered by another professional liability policy? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage.
- N. Are you a preceptor physician for any physician assistant, nurse practitioner or any nurse midwife who is not your employee?
 Yes No If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage.

SECTION VI - HOSPITAL PRACTICE INFORMATION

- A. List each institution where you have admitting privileges and estimate the total number of patients admitted and outpatient 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%)
1.						
2.						
3.						
4.						

* Indicate: A = Active, CS = Courtesy, CN = Consulting

SECTION VII - PROFESSIONAL INFORMATION

Please answer YES or NO. If your answer is YES to any of the following questions indicate the date and state (if applicable) where action occurred. Please give full details on the Additional Comments Section.

- A.**
1. Have you had a denial, restriction, suspension, probation, or revocation of privileges by a hospital or other health care facility? Yes No Date _____ State _____
 2. Have you entered into any consent agreement related to your privileges with any formal committee of a hospital or other health care facility? Yes No 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 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 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 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 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
Date _____
 6. Have you been declined, non-renewed, or cancelled by an insurance carrier with cause (excluding market withdrawal)?
 Yes No 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 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
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 Date _____

SECTION VIII - MEDICAL TRAINING AND WORK HISTORY INFORMATION

Name of <u>Medical School(s)</u> Attended	Location	Degree	Date Graduated

Name of Hospital Where <u>Internship</u> Served		Location of Hospital Where Internship Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Hospital Where <u>Residency</u> Served		Location of Hospital Where Residency Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Hospital Where <u>Fellowship</u> Served		Location of Hospital Where Fellowship Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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)

Please use the *Additional Comments Section* to provide additional training programs or explain gaps between training programs or work history. Attach a copy of your Curriculum Vital.

- A. 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
If “**Yes**”, attached a copy of Certificate.
- B. Do you average at least 50 hours of Category I CME units annually in your specialty? Yes No
- C. Are you entering private practice for the first time? Yes No

SECTION IX - PROFESSIONAL LIABILITY INSURANCE HISTORY INFORMATION

- A. Have you ever practiced without professional liability coverage? Yes No
- B. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage (tail coverage)? NA Yes No
- C. 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
 If questions A–C are answered “Yes”, please provide a detailed description in *Additional Comments Section* or on a separate sheet.
- D. If prior carrier was not the SC JUA, please provide information on your Professional Liability Insurance carrier for the previous five years. **(IF THIS IS NEW BUSINESS 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	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date					
Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Rating Classification					

SECTION X - PRACTICE ORGANIZATION INFORMATION

A. Please check the boxes in A1 and A2 that best describe your practice affiliations(s):

A1. Employment Status:

- Employee
 Shareholder/Partner
 Independent Contractor
 Solo Unincorporated/Sole Proprietor
 Intern/Resident/Fellow
 Other: _____

A2. Entity Type

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

B. Name of practice/entity organization: _____

- C. Is the purpose of the entity other than a medical office practice? Yes No
- D. Do you have any office or expense sharing arrangements with any other physician(s) or practice group(s) not disclosed? Yes No
- E. Are there any subsidiaries of this business entity that provide health care related services? Yes No
- F. Is the entity eligible to be licensed to provide medical professional services? Yes No
 If “Yes”, attach a copy of the license to the application.

G. Please list all physicians who are your employees and/or independent contractors. (List the full name, status, current professional liability carrier). If the employee or independent contractor is not insured with the SC JUA, please attach a copy of their Declaration Sheet or Certificate of Insurance.

	Full Name	Status Code *	Current Carrier	Is Coverage Desired with SCJUA (Y or N)?
1.				
2.				
3.				

* Status Codes - E = Employee, P = Partner, C= Independent Contractor, O=Other

Please use *Additional Comments Section* or separate sheet if additional space is required or to further explain response.
(Each member is required to submit an individual application.)

H. Does the entity name in question "B" above currently maintain professional liability coverage? Yes No
 Is this form of coverage Occurrence or Claims-Made?
 If Claims-Made, what is the retroactive date used by the current carrier (MM/DD/YY): _____

I. Date of Incorporation (MM/DD/YY): _____ J. Corporate Tax Identification Number: _____

J. Do you desire coverage for the business entity named in question "B" above? Yes No
 If "yes" do you wish to share your individual policy limits with this business entity? Yes No
 If "no" and separate limits are desired, you must purchase a separate policy. See JUA Form A100 (Rev. 11-2006).

K. ADDITIONAL INSURED ENDORSEMENT: "STAFF COVERAGE ENDORSEMENT"

Do you wish to include your other employees as additional insureds? (Staff Coverage Endorsement includes RNs, LPNs, medical assistants, lab techs, X-ray techs, and administrative staff) Yes No

*This endorsement provides coverage for these employees while acting within the scope of their duties as such. If you elect coverage for these employees, the Association also agrees to pay on your behalf all sums you shall be obligated vicariously to pay as damages because of any claim or claims made against you arising out of a medical incident which is caused by your employee during the policy period. This endorsement may not be used to extend individual coverage to *physicians, dentists, pharmacist, chiropractors, podiatrists, nurse anesthetists, physician assistants, anesthesia assistants, nurse practitioners, nurse midwives, perfusionists, or surgical techs. *These providers must have their own individual coverage.*

SECTION XI - PROFESSIONAL EMPLOYEES OF AN INDIVIDUAL PHYSICIAN

COMPLETE THIS SECTION ONLY IF YOU ARE THE EMPLOYER AND YOU DO NOT HAVE A SEPARATE PROFESSIONAL LIABILITY POLICY FOR YOUR ENTITY.

An individual employer may incur a legal responsibility for the actions of his/her employee(s). Additional charges shall be made for the employee(s) to reflect this exposure. The additional charge does not contemplate that coverage will be provided to the employee(s), but only contemplates liability imparted to the employer. Do you employ any of the following?

- | | | | |
|--|------------------------------|-----------------------------|-----------------|
| 1. Radiation Therapy - Employed Physician or Surgeon | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 2. Shock Therapy – Employed Physician or Surgeon | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 3. Employed Technician – Radiation Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 4. Employed Technician – X-Ray or Pathological | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 5. Employed Surgical Technician | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 6. Employed Physician Assistant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 7. Employed Nurse Midwife | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 8. Employed Nurse Practitioner | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 9. Employed Nurse Anesthetist | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 10. Employed Licensed Therapist | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 11. Employed Licensed Estheticians | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |
| 12. Other (please specify): _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many? _____ |

If yes to #5, 6, 7, 8, 9, 10 or 11 provide their names and their policy numbers

SECTION XII - CLAIMS INFORMATION

Important information regarding questions in Section IX A and B

- ▶ The word "claim" and "circumstance" as used in Questions A and B 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 but 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.
- ▶ Please complete the attached *Malpractice Claims History Explanation Form* for each case reported in A 3.

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

If "Yes", please indicate number of cases below:

- | | | Where (County and State) |
|-----------------------------------|--------------|---------------------------------|
| 1. Current number <u>open</u> : | _____ | _____ |
| 2. Current number <u>closed</u> : | _____ | _____ |
| 3. <u>Total</u> number of cases: | _____ (1 +2) | _____ |

If "Yes" have all been reported to your current or prior professional liability insurer? NA Yes No

B. Other than the claims/suits indicated in question A 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

If "Yes", how many? _____ Please attach details of each circumstance.

If "Yes" have all been reported to your current or prior professional liability insurer? NA Yes No

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

- C. 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

SECTION XIII - MALPRACTICE CLAIMS HISTORY EXPLANATION FORM

Malpractice Claims History Explanation

Please complete one for EACH such case, potential claims, or suit reported in Section XII - A and B. Please photocopy this form. All questions must be answered or marked not applicable (NA).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Carrier: _____ File Number: # _____ Telephone #: _____

Address of Insurance Carrier: _____

Date Reported to Insurance Company: _____ Date of incident, treatment and or surgery: _____

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
- Summary judgment in your favor
- Suit settled out of court
- Suit threatened, no action taken
- Jury verdict in your favor
- Suit filed awaiting mediation
- Suit filed but dropped by claimant
- Jury verdict in favor of the plaintiff
- 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: \$ _____

SECTION XIV - ADDITIONAL COMMENTS SECTION

Section

Question

Explanation/Comments

SECTION XV - SCMA 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.)

_____ I am beginning my first year of practice since the completion of my medical training, and I agree to qualify
Initial here for a 25% first year premium reduction subject to a maximum \$2,000 premium reduction by completing the
if applicable South Carolina Medical Association's Risk Management Program during my first year of practice. This discount
is in the form of an endorsement with a return premium credit issued upon receipt of SCMA certificate of
completion for the Risk Management program. (Please contact SCMA to obtain further information regarding the
risk management seminar 800-327-1021.)

**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.** _____ **Initial here**

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 have occurred but are not yet reported. _____
Initial here

**D. Signing this application does not bind the JUA 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 Liability Insurance Joint Underwriting Association and that my JUA 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 JUA or any of its brokers relating to this insurance.** _____ **Initial here**

Date _____

Signature of Applicant _____

Broker must 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.

Date _____

Signature of Broker _____

*The information contained in this application 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
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.*