SOUTH CAROLINA | JUA *the medical liability experts*

South Carolina Joint Underwriting Association
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PART TIME HEALTHCARE PROVIDER CREDIT APPLICATION

Instructions:

1. Sign and date this form and fax to the SCJUA. 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 SCJUA 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 SCJUA are for rating purposes and are subject to audit at the SCJUA's discretion.*
- *Providers who are subject to experience rating are not eligible for this part time discount.*

A. FAX COVER INFORMATION:

TO:
SCJUA Underwriting Department
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 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. PERSONAL DATA FOR APPLICANT:

1. Applicant name: _____

1a. Billing address:

Street Address or PO Box: _____

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

5. Applicant policy information:

5a. JUA Policy #: _____ 5b. PCF Member ID #: _____

6. Part time practice name: _____

7. Part time practice address:

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 Joint Underwriting Association.

_____ _____ / _____ / _____

Signature of Applicant Date

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