

PRACTICE ENTITY APPLICATION – RENEWAL SHORT FORM

Assessable Policy

Instructions:

1. Please answer ALL questions completely, leaving no blanks. (Use N/A if Not Applicable)
2. If you need more space for responses, 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.
4. Please submit the completed application, along with a copy of the insured practice’s business letterhead and any other required additional information.
5. Please contact the SCJUA Underwriting Department if you have any questions.

A. POLICY INFORMATION:

Important: The SC JUA offers limits of liability of \$200,000 per claim / \$600,000 annual aggregate. For additional coverage, please contact the SC Patients’ Compensation Fund at 803-896-5290 or www.scpcf.com

1. Current Policy #: _____ 1a. Expiration Date: ____ / ____ / ____
2. Policy Type: (Check all that apply) Occurrence Claims Made Separate Policy Entity Shared Limits Endorsement

B. GENERAL INFORMATION:

3. The precise name of the insured practice entity:
 Name: _____ Federal ID # _____
 3a. List names of all other entities to be insured (if applicable) in the *Additional Comments Section* of this application.
4. Preferred Billing Address (Your invoice will be mailed to this address.)
 P.O. Box or Street: _____
 City: _____ State: _____ Zip: _____
5. Practice Address:
 Street Address 1: _____
 Street Address 2: _____
 City: _____ State: _____ Zip: _____
6. Do you have additional office locations not listed above? Yes No
 6a. If “Yes”, please list additional offices in *Additional Comments Section*.
7. Office Telephone Number: _____ 7a. Fax Number: _____
 7a. May we contact you by fax? Yes No
8. Contact Name: _____ 8a. Contact Title: _____
9. Contact Email Address: _____ 9a. May we contact you by email? Yes No
10. Practice Entity Web Address: _____

C. PHYSICIANS / DENTISTS / PODIATRISTS / OPTOMETRISTS / PHARMACISTS:

11. Please list below the names of all physicians/dentists/podiatrists/optometrists and pharmacists who are associated with your practice entity. You must check whether the participant is a member/owner (an individual who has an ownership interest in the practice), or an employee (an individual who does not have an ownership interest). NOTE: Independent contractors are considered to be employees for underwriting purposes.

| | <u>NAME</u> | <u>SPECIALTY</u> | <u>MEMBER/OWNER</u> | <u>EMPLOYED</u> | <u>JUA INSURED</u> |
|----|-------------|------------------|--------------------------|--------------------------|---|
| a. | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Y <input type="checkbox"/> N |
| b. | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Y <input type="checkbox"/> N |
| c. | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Y <input type="checkbox"/> N |
| d. | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Y <input type="checkbox"/> N |
| e. | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Y <input type="checkbox"/> N |
| f. | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Y <input type="checkbox"/> N |

If more space is needed, continue on a separate sheet. Please inform the JUA of any changes as they occur.

IMPORTANT: If "NO" is indicated under "JUA 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.

D. OTHER PROFESSIONAL EMPLOYEES/INDEPENDENT CONTRACTORS:

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

- 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): _____

12a. **IMPORTANT:** If you answered "Yes" to "d" through "j", please list the individual's names, specialty, carrier, policy number, and limits of coverage in the space provided below. The practice entity policy form does NOT extend individual coverage to these individuals.

| <u>Name</u> | <u>Specialty</u> | <u>Carrier Name</u> | <u>Policy No.</u> | <u>Limits</u> |
|-------------|------------------|---------------------|-------------------|---------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

If more space is needed, continue on a separate sheet. Please inform the JUA of any changes as they occur.

E. EMPLOYEES AS ADDITIONAL INSUREDS ENDORSEMENT - "STAFF COVERAGE":

The **Employees as Additional Insureds ("Staff Coverage") Endorsement** 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.

13. Do you wish to add the Employees as Additional Insureds Endorsement? Yes No

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 JUA. Different applications may be required depending on medical specialty. Contact the JUA Underwriting Department or visit SCJUA.COM for more information and applications.

F. ORGANIZATIONAL INFORMATION:

14. Entity Type: Please check any that apply.

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

15. Is the purpose of the entity other than a medical or dental office practice? Yes No
 15a. If "Yes", please explain in the *Additional Comments Section*.

16. Do you have any office or expense sharing arrangements with any other physician(s) or practice group(s)? Yes No
 16a. If "Yes", please explain in the *Additional Comments Section*.

17. Do you own or operate a surgery center, laboratory or other outpatient facility? Yes No
 17a. If "Yes", do you have coverage under a separate policy for this exposure? Yes No
 17b. If "Yes", please explain in the *Additional Comments Section*.

18. Do you participate in pharmaceutical testing programs/clinical investigation studies? Yes No
 18a. If "Yes", do you have coverage under a separate policy for this exposure? Yes No
 18b. If "Yes", please explain in the *Additional Comments Section*.

19. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? Yes No
 19a. If "Yes", do you see these patients in (check all that apply):
 your office,
 a correctional facility?

20. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees or has your ability to participate been revoked, suspended, placed on probation or voluntarily surrendered? Yes No
 20a. If "Yes", please explain in the *Additional Comments Section*.

21. Are you in any way affiliated with a medical spa or weight loss facility? Yes No
 21a. If "Yes", please explain in the *Additional Comments Section*.

G. BROKER INFORMATION:

22. Agency Name: _____
 Street Address 1: _____
 Street Address 2: _____
 City: _____ State: _____ Zip: _____
 Agency Contact Person: _____
 Agency Contact E-mail: _____

H. TERRITORY:

80% of your practice must be in South Carolina. Up to 20% of your practice may be across state lines. 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 JUA.

I. ADDITIONAL COMMENTS SECTION:

If more space is needed, please continue on a separate sheet.

J. AGREEMENT:

Signing this application does not commit the JUA to bind 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/agents relating to this insurance.

_____/_____/_____
 Signature of Applicant (Authorized Representative) Date

 Title

 Insured Practice Entity Name

REMINDER:
 Please attach a sample of your practice entity letterhead to this application.

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.