LOUISIANA PATIENT'S COMPENSATION FUND GROUP APPLICATION

(RENEWAL FOR FTE's, Locum Tenens, Clinics, ER Groups, Surgical Centers with PRIMARY INSURANCE)

PCF5R
05/01/2015
13:33:40

1. PROVIDER DETAILS

***Complete Name & Mailing Address**

Complete Name - Required

Street Address Line 1 - Required

Street Address Line 2

City, State Zip Code - Required

LICENSE #: _____
License Number - Required

Professional Specialty: _____
Professional Specialty - Required

PCF Code: _____

Phone #: _____

EMAIL: _____

2. PRIMARY COVERAGE -- The COI or declarations page from the insurer's policy is REQUIRED.

Insuring Company: _____
Insuring Company - Required Field

Policy #: _____ **Effective From:** _____ **To:** _____
Effective Date - Required
Expiration Date - Required

Retro Date (if applicable)*:** _____

Policy Form: ____ **Claims Made*** or Occurrence** ____
Policy Form Selection - Required

Primary Premium: _____ **PCF Surcharge:** _____

Professional Liability Limits: _____ **Each Claim/** _____ **Aggregate**

If Locum Tenens, what physician are you covering for: _____

Hospitals you service: _____

NUMBER OF OUTPATIENT VISITS/DRAWS/PROCEDURES: _____

TYPE OF FTE'S	NUMBER OF FTE'S

Must advise the PCF of any offsite entities or multiple locations for which coverage is provided along with the address for each location and proof of underlying coverage.

EMPLOYEES AS ADDITIONAL INSUREDS: Please see below inclusions/exclusions; complete the proper form and include proof of underlying coverage.

INCLUSIONS: Employed allied healthcare providers.
EXCLUSIONS: This does not include those who require a PCF surcharge, such as, NP's, PA's, CNS', CRNA's, etc.
PCF RESERVES THE RIGHT TO DENY COVERAGE FOR THE FOLLOWING:

(1) Injury arising out of a criminal act, including but not limited to sexual abuse or molestation, fraud committed by the insured or any person for whom the insured is legally responsible, and battery.
(2) Third (3rd) party claims filed by an injured party that was not a patient of the health care provider.
(3) Services or treatment rendered as a licensed provider in states other than Louisiana, even if the underlying insurer provides coverage for same.

NOTE: *Failure to comply with cost and reserve reporting requirements set forth in LAC 37:III, §§1101-1105 could result in termination of PCF coverage.*

05/01/2015

Date **Printed Name of Insured** **Signature of Insured -- NOT VALID WITHOUT SIGNATURE**

Any questions regarding this form may be emailed to: pcf-surcharge@la.gov

A PRINTED, SIGNED COPY OF THIS FORM MUST BE MAILED/FAXED TO PCF. **Save & Print**