May 29, 2007

Bulletin 148

Indiana Patient's Compensation Fund - Filings

This Bulletin is directed to all insurers that provide coverage to health care providers under Indiana's Medical Malpractice Act. Portions of Bulletin 119 relating to the Certificate of Insurance are hereby withdrawn and replaced by this Bulletin 148. All other provisions of Bulletin 119 remain in effect.

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Pursuant to IC 34-18-3-2 a health care provider may qualify under the Indiana Medical Malpractice Act by filing with the Department of Insurance proof of financial responsibility and payment of a surcharge to the Indiana Patient's Compensation Fund. Attached to this Bulletin as Exhibit A is the certificate that shall be used when filing proof of financial responsibility with the Patient's Compensation Fund on or after July 1, 2007.

INDIANA DEPARTMENT OF INSURANCE

James Atterholt, Commissioner

EXHIBIT A

CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return Surcharge	☐	$_____	_____
Additional Surcharge	☐	$_____	_____

Surcharge Change Reason: _____

Health Care Provider:			Medical License No. (Individual):		
			EIN# (Entity): Please do not provide individual social security number		
Address (Street, City, State, Zip):			County of Service:		
Policy No.:	Occurrence ☐ Claims Made ☐ Reporting Endors. ☐		Retro Date (CM or RP)	Including employees ☐ Excluding employees ☐	
Coverage Dates: From: _____ To: _____	ISO Code:		Date Surcharge Rec'd from Provider:		
Limits of Liability: $_____ per occurrence $_____ annual aggregate	Premium: **(IN P/L Only)**	Surcharge:	Under 90 day Penalty:	Over 90 Day Penalty:	

The following credits are only available for health care providers identified under Rule 60:

Credits: **(Only one credit may be applied)**	Part-Time Credits	Medical School Faculty	Newly Licensed Physicians	Fellowship
	☐ 0-12 hrs. 75% ☐ 13-25 hrs. 50% ☐ 26-30 hrs 25%	☐ 67% ☐ Retired	☐ 1st yr. 50% ☐ 2nd yr. 25%	☐ Full-Time 50% **Greater of:** ☐ Full-time surcharge for medical practice outside fellowship ☐ 50% of surcharge due for specialty class of fellowship

Insurance Carrier Name:	NAIC#
Contact Name:	Telephone Number/Email:

The undersigned Insurance Company/Broker, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital or nursing home, or is One Hundred and Ten Percent (110%) of the premium for non-physician, non-hospital or non-nursing home providers. Said Company/Broker also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days of receipt but not more than sixty (60) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of _____

Signed by: _____
Authorized Signature

Printed: _____

Title: _____