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 (if d/b/a, must include full name or if multiple, attach list of all d/b/a's)	Medical License No. (Individual):
Email Address to send PCF Enrollment Confirmation:	EIN# /License# (Entity):
Address (Street, City, State, Zip):	

Policy No.:	Occurrence ☐ Claims Made ☐ Reporting Endors ☐	Retro Date (Form CM or RP)	Including employees ☐ Excluding employees ☐	ISO Code:

Coverage Dates: From: _____ To: _____	Limits of Liability: $_____ per occurrence $_____annual aggregate

Date Surcharge Rec'd from Provider:	IN P/L Premium Only:	Surcharge:	Pro-Rated ☐ 2nd Policy ☐ Locum ☐	Under 90 day Penalty:	Over 90 Day Penalty:

Following credits are available for health care providers identified under Rule 60 and only part-time credits are available to those providers identified as Independent Ancillary Providers per Rule 21:

Credits: **(Only one credit may be applied)**	Part-Time Credits ☐ 0-12 hrs. 75% ☐ 13-24 hrs. 50% ☐ 25-30 hrs 25%	Medical School Faculty ☐ 67% ☐ Retired	Newly Licensed Physicians ☐ 1st yr. 50% ☐ 2nd yr. 25%	Fellowship ☐ 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: (Person Completing Form)	Telephone Number: Email:

The undersigned Insurance Company Representative/Producer hereby certifies limits of liability on behalf of the Health Care Provider indicated in this PCF Certificate of Insurance of the amount indicated in this filing, no more nor less, for claims against the Health Care Provider as a result of medical malpractice within the State of Indiana. I further certify that the policy used as proof of financial responsibility complies in all respects with the provisions of the Indiana Medical Malpractice Act, Indiana Code 34-18-1-1, et seq., and that any provision in the policy attempting to limit or modify the liability of the Health Care Provider contrary to the Medical Malpractice Act is void.

I further certify 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 Independent Ancillary Provider, or is One Hundred Percent (100%) of the premium for other health care providers. I also agree surcharge for this policy was remitted to the Patient's Compensation Fund within thirty (30) days of receipt from provider, but not more than sixty (60) days from the effective date of said policy, unless otherwise indicated in this filing.

I further acknowledge that in the event of a termination of the policy, or an amendment reducing, restricting, or removing coverage to the policy indicated in this filing, such change or termination shall not be effective unless notice of same has been delivered to the Insurance Commissioner not less than thirty (30 days prior to such change or termination. Notice shall be considered to have been given upon amending or terminating the policy and 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 _____

Authorized Signature:	Printed Name:	Title: