

**\*\*\*CLAIMS-MADE POLICY:**

Your primary insurance policy provides CLAIMS MADE coverage for professional liability. Except to the extent as may otherwise be specifically provided in your policy, such primary coverage is limited to claims arising from medical incidents occurring on or after the initial effective date stated in the declarations ("retroactive date") and first reported to your company while the policy is in force. HOWEVER, THE PCF RETROACTIVE DATE IS THE DATE OF YOUR QUALIFICATION WITH THE FUND, WHICH MAY OR MAY NOT MATCH THE RETROACTIVE DATE ESTABLISHED ON YOUR PRIMARY POLICY. Claims occurring prior to the qualification date with the Fund, REGARDLESS OF THEIR COVERAGE THROUGH YOUR PRIMARY POLICY, are not covered by the Fund.

The above indicated insurance company hereby certifies limits of liability, on behalf of the Health Care Provider referenced above, of not less than one hundred thousand (\$100,000.00) dollars for each claim against said Health Care Provider during the policy term as a result of medical malpractice or allegations thereof. The Insurance Company further certifies that said policy of insurance complies in all respects with the provisions regarding financial responsibility of health care providers as set forth in La. R.S.40:1299.41 et seq.

It is further certified that Agent of said company agrees to remit the required surcharge amount for coverage excess of primary limits to the Louisiana Patient's Compensation Fund, as set further in La.R.S. 40:1299.44 A. (3).

It is further acknowledged that in the event of termination of policy herein, or any endorsed reduction of liability limits, such termination or change shall not be effective unless such notice of the same has been delivered to the Louisiana Patient's Compensation fund 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 Mail, a copy of which shall have been mailed to the Health Care Provider.

October 29, 2008

Date



800-247-8043

Signature & Phone Number of Authorized Representative  
Not Valid Unless Signed by a Duly Authorized Representative

**PART 3: LOUISIANA PATIENT'S COMPENSATION FUND**

It is agreed that the insured under the above primary limits has been advised by the Company's Agent:

(1) that he or she is eligible to qualify for coverage under the Louisiana Patient's Compensation Fund for the provisions of La. R.S. 10:1299.41 et seq., as a "health care provider" that is already carrying underlying malpractice liability coverage at limits of \$100,000.00/\$300,000.00 or more:

(2) that to qualify, the insured undertakes to pay the required surcharge, and this surcharge will be collected by the Company's Agent and remitted to the Fund on a calendar-year basis; and

(3) that if qualified, the insured is entitled to a \$500,000 limitation of malpractice liability for death, or injury to any person and to coverage under that Fund for an excess liability (over the minimum underlying limits required by the Fund) up to a per claim limit of \$500,000.

**(4) COST AND RESERVE REPORTING REQUIREMENTS:**

By the signature below, I acknowledge and agree that the Patient's Compensation Fund has hereby given notice to the Insured of the cost and reserve reporting requirements set forth in LAC 37:III, §§1101-1105.

**(5) CLAIMS MADE PRIMARY POLICIES ONLY:**

I understand that, regardless of the retroactive date established by my primary policy, I will only receive coverage through the Fund for claims which occur after my qualification with the Fund. For a claim to be covered by the Patient's Compensation Fund, I must have been qualified with the Fund both at the time the medical incident occurred, and at the time the claim was filed with my primary carrier.

I wish to qualify for coverage under the provisions of La. R.S. 40:1299.41 et seq. I am therefore returning a copy of this statement to my insuring company, NCMIC INSURANCE COMPANY and/or agent \_\_\_\_\_, with a check for \$\_\_\_\_\_ payable to the Louisiana Patient's Compensation Fund.

**TO: LOUISIANA PATIENT'S COMPENSATION FUND  
P. O. BOX 3718  
BATON ROUGE LA 70821**

DATE

Signature of Insured  
NOT VALID WITHOUT SIGNATURE

**This endorsement is subject to all agreements, conditions and exclusions of the policy unless such agreements, conditions and exclusions are expressly eliminated hereby.**