SOUTH CAROLINA | JUA *the medical liability experts*

South Carolina Joint Underwriting Association
550 South Main Street, Suite 525, Greenville, SC 29601 *corporate office*
Lock Box 932523, Atlanta, GA 31193-2523 *payment remittance address*
864.240.5449 *main* 866.893.6270 *toll-free* 864.240.2750 *fax*
www.scjua.com

THE SOUTH CAROLINA JUA *is a not-for-profit association established to insure, support and defend South Carolina medical professionals. The association is managed by Marsh USA, Inc.*

LOCUM TENENS COVERAGE REQUEST FORM

Instructions:

1. Please complete this form leaving no blanks.
2. The Locum Tenens Coverage Request form must be signed and dated by the JUA insured.
3. Please submit the completed form to the SCJUA via email at teresa.anderson@marsh.com, fax, or regular mail. You may use this page as a fax cover sheet.
4. Once request is approved, a Locum Tenens Endorsement will be sent to you as evidence of coverage.
5. Please contact the SCJUA if you have any questions.

A. FAX COVER INFORMATION:

TO:

JUA Locum Tenens Request
Fax # 864-240-2750
____

FROM:

____ Date: _____ / _____ / _____
Authorized Practice Representative Name

PRACTICE NAME: ____

NAME OF JUA INSURED REQUESTING LOCUM TENENS COVERAGE: ______________________________

Phone:____

Fax: ____ Total # of Pages: ___________

The information contained in this transmission 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 transmission is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone and return the original message to the South Carolina JUA via the U.S. Postal Service. Thank you.

B. General Locum Tenens Coverage Information:

Locum Tenens coverage is insurance for a healthcare provider who substitutes for a JUA insured during periods of temporary absence. This coverage can be provided only when the JUA insured is not practicing. JUA policies may be eligible for up to 45 days of Locum Tenens coverage per annual policy period. If you need an extension beyond the 45 day limit, you may request such an extension by submitting your request in writing to our office. The substituting provider must submit a completed SCJUA Locum Tenens Healthcare Provider Application to the JUA for approval. Once approved, Locum Tenens providers will remain eligible for coverage for one year.

A separate SCJUA Locum Tenens Coverage Request Form is required for each substitute period, and must be signed by the JUA insured. Requests for this coverage must be made prior to the beginning of each substitution period. Locum Tenens coverage cannot be provided on a retroactive basis if the request is made late.

Please contact the Patients' Compensation Fund directly for excess Locum Tenens coverage. If you have any questions about Locum Tenens coverage, or require special assistance, please contact the JUA Underwriting Department.

Important: *The coverage afforded by this endorsement is excess insurance should the substitute provider have other insurance applicable to the loss under this policy. On an excess, contingent, or primary basis, this policy will come into effect only after such other insurance has been exhausted. This endorsement excludes all professional services rendered outside the state of South Carolina.*

C. Locum Tenens Coverage Request Details:

1. JUA Insured Name (please print): ______________________________

2. JUA Insured Policy Number: ______________________ 2a. PCF Member ID Number: ______________________

3. JUA Insured Policy Period: Effective Date: _____ / _____ / _____ Expiration Date: _____ / _____ / _____

4. I request Locum Tenens coverage for the following substitute healthcare provider:

   Name: ______________________________

   Mailing Address: ______________________________

   City: ______________________ State: ______________ Zip: ______________

5. Insured's normal Shift/per Day is: ____________ Hours per Shift/Day ______________Shifts/Days per Week

6. Requested Locum Tenens Coverage Period (Please request non-continuous coverage on a separate line):

Coverage Date(s)	Shift: Start Time	to	End Time	*JUA Use Only:* Total LT Days
________	________	to	________	________
________	________	to	________	________
________	________	to	________	________
________	________	to	________	________

7. Return Locum Tenens Endorsement to my office to the attention of: ______________________________

8. Return Locum Tenens Endorsement to my office via: ☐ Fax ☐ Email

   8a. If "Email" checked above, please provide e-mail address: ______________________________

D. AUTHORIZATION:

______________________________ _____ / _____ / _____

Signature of JUA Insured Date

The information contained in this transmission 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 transmission is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone and return the original message to the South Carolina JUA via the U.S. Postal Service. Thank you.