PCF CERTIFICATE OF INSURANCE

State Form 2713 (R6 / 04-26)
INDIANA DEPARTMENT OF INSURANCE

INDIANA DEPARTMENT OF INSURANCE
PATIENT'S COMPENSATION FUND
311 W. Washington St, Ste 103
Indianapolis, IN 46204
Telephone: (317) 232-5065
E-mail: PCF-COI@idoi.in.gov
Website: in.gov/idoi/medical-malpractice

THIS CERTIFICATE IS ISSUED BY THE INSURANCE COMPANY REPRESENTATIVE OR PRODUCER ON BEHALF OF THE NAMED HEALTH CARE PROVIDER. THIS CERTIFICATE IS NOT PROOF THAT THE HEALTH CARE PROVIDER IS A QUALIFIED HEALTH CARE PROVIDER UNDER THE INDIANA MEDICAL MALPRACTICE ACT FOR THE POLICY PERIOD LISTED.

I. CERTIFICATE INFORMATION

Certificate Type *(Select One)*	Confirmation Number	Cancelled / Effective Date *(mm / dd / yyyy)*
◉ New / Renewal ○ Amendment / Cancellation / Void Cancellation (select one)		

Surcharge / Returned Surcharge	Penalties 31-90 days (10%)	Penalties 91+ days (20-50%)	Payment Method *(select one)*
$	$	$	

Amend / Cancel / Void Cancellation Reason

II. PROVIDER AND POLICY INFORMATION

Health Care Provider Name (Must include full name and attach list of all DBAs)	License Number (Individual, Hospital, or Facility)	Provider PCF ID	ISO Code

Business Mailing Address (Number and street, city, state, and ZIP code)

Policy Number	Policy Type *(select one)*	Coverage Dates *(mm / dd / yyyy)*
		From: To:

Retro Date *(CM or RE)*	Date Surcharge Rcvd	Employees (select one)	IN P/L Premium Only	Limit Per Occurrence	Annual Aggregate
			$	$	$

Credits (select one)	Prorated / Locum Tenens (select one)	Locum Days

III. INSURANCE CARRIER INFORMATION

Carrier NAIC No.	Insurance Carrier Name

Contact Name	Contact E-mail Address	Contact Telephone Number

The undersigned Insurance Company Representative / Producer hereby certifies the limits of liability on behalf of the Health Care Provider indicated in this PCF Certificate of Insurance is 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 underlying premium for other health care providers. I also certify surcharge for this policy was remitted to the Patient's Compensation Fund within thirty (30) days of receipt from the 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 an amendment to or termination of 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.

Authorized Signature *(Ins. Co. Rep. or IN Licensed Producer)*	Printed Name	Date

Email Address	Insurance Carrier / Firm Name	Title *(Ins. Co.)* / Lic. No. *(Producer)*

INSTRUCTIONS

I. CERTIFICATE INFORMATION

1. Select the Certificate Type: either New / Renewal or select from Amendment, Cancellation, or Void Cancellation.
2. For Amendments, Cancellations, or Void Cancellations, enter the Confirmation Number and the Cancelled / Effective Date.
3. Enter the Surcharge or Returned Surcharge amount; enter $0 if none.
4. If surcharge is due, enter Penalties; enter $0 if none.
5. Select the Payment Method: Check / Money Order, PCF COI eFiling Account Credits or N/A (if no surcharge is due).
6. For Amendments, Cancellations, or Void Cancellations, enter the Amend / Cancel / Void Cancellation Reason.

II. PROVIDER AND POLICY INFORMATION

1. Enter the full Health Care Provider Name as it appears on the applicable license or organizational documents; attach a list of DBAs if applicable.
2. Enter the Indiana or Compact License Number of an individual, the IDOH License Number of a hospital, the DMHA License Number of a Private Mental Health Institution, or the IDOH License Number of a nursing home.
3. Enter the Indiana PCF Provider ID from IndianaPCF.com.
4. Enter the ISO (Specialty Class) Code using 760 IAC 1-60 and the Rule 21 Rate Chart; consult the provider or underwriter to determine the appropriate ISO Code.
5. Enter the provider's Business Mailing Address; do not use a home address.
6. Enter the Policy Number.
7. Select the Policy Type: Claims Made, Occurrence, or Reporting Endorsement.
8. Enter the Policy Coverage Dates.
9. For claims made policies or reporting endorsements, enter the Retro Date.
10. Enter the date the PCF Surcharge was received.
11. Select whether employees are included or excluded; for individuals, select Not Applicable.
12. Enter the premium for the underlying policy.
13. Enter the policy limits, ensuring they meet statutory minimums.
14. Select applicable credits. (Note: Credits are available to providers identified in Rule 60. Part-time credits are also available to IAPs identified in Rule 21.):
    - None / Not applicable
    - Part-Time Credits: 0-12 hrs. (75%)
    - Part-Time Credits: 13-24 hrs. (50%)
    - Part-Time Credits: 25-30 hrs. (25%)
    - Fellowship:
        - Full time, no medical practice outside of fellowship (50%)
        - If the physician is engaging in medical practice outside of the fellowship, greater of:
            - The full-time surcharge for the medical practice outside of the fellowship
            - Fifty percent of the surcharge for the specialty class of the fellowship (50%)
    - Newly Licensed Physicians: First Year (50%)
    - Newly Licensed Physicians: Second Year (25%)
    - Medical School Faculty (67%)
    - Retired Physician ($500)
    - Second Policy ($100)
15. Select whether the policy is subject to proration: Locum Tenens, Prorated, or None / Not applicable.
16. For locum tenens filings, enter the number of covered days.

III. INSURANCE CARRIER INFORMATION

1. Enter the Insurance Carrier's NAIC Number, or the AA-number for an Alien Insurer.
2. Enter the Insurance Carrier's Name; for Alien Insurers, include the syndicate number (if there is more than one syndicate, list all syndicates with risk percentages on a separate sheet).
3. Enter the Contact Person's Name.
4. Enter the Contact Person's E-mail Address.
5. Enter the Contact Person's Telephone Number.
6. Provide the Authorized Signature of an Insurance Company Representative or Indiana Licensed Producer.
7. Enter the signer's Printed Name.
8. Enter the Date that the certificate was signed.
9. Enter the signer's Email Address.
10. Enter the signer's Insurance Carrier or Firm (Agency) Name.
11. Enter the signer's job title if representing a carrier or their Indiana License Number if they are a Producer.