LOUISIANA PATIENT'S COMPENSATION FUND
CORPORATION APPLICATION
(for those with underlying self-insurance and primary insurance)

NAME & PHYSICAL ADDRESS OF CORPORATION
(Please designate whether it is APMC, AMC APC, INC, LLC, LLP, Trade Names, etc.)

Name of Corporation - Required

Corporation's Physical/Street Address - Required

Corporation's Address Line 2

City, State, and Zip Code - Required

DATES OF ENROLLMENT APPLYING FOR: _____ **TO:** _____

Enrollment Dates are Required and Must Coincide with Dates of Underlying Coverage

LIST ALL OWNERS, CO-OWNERS, SHAREHOLDERS AND/OR PARTNERS OF THIS CORPORATION

Name	Title

For Self Insured:
I further certify that the appropriate security (proof of financial responsibility) is in place and current at the following institution:

_____ in the name of _____

For those with primary insurance, please provide a copy of the COI or declarations page from the insurer's policy evidencing coverage for the corporation.

Name of Employees (other than owners) including contract employees. Only list employees who are eligible to enroll in the Fund (healthcare providers)	Title and/or Association

09/14/2023

DATE **SIGNATURE OF AUTHORIZED REPRESENTATIVE**

CONTACT PERSON AND PHONE #: _____

CONTACT EMAIL ADDRESS: _____

After form has been completed, printed and signed, please mail or fax to:

LOUISIANA PATIENT'S COMPENSATION FUND
SURCHARGE DEPARTMENT
P. O. BOX 3718
BATON ROUGE, LA 70821
PHONE #: (866) 469-9555
FAX: (225) 342-5593

Any questions regarding this form may be emailed to:
pcf-surcharge@la.gov
A PRINTED, SIGNED COPY OF THIS FORM MUST BE MAILED/FAXED TO PCF.

Save & Print