



COOPERATIVE OF
AMERICAN PHYSICIANS

**APPLICATION FOR DISABILITY STATUS
THROUGH MUTUAL PROTECTION TRUST (MPT)**

Member Name: _____

Member #: _____

I understand that in order to be eligible for disability status with MPT I must be unable to perform any and every duty of my regular professional occupation. Part 2, Section 4 of the MPT Agreement provides that the regular professional occupation of all MPT members shall be deemed to be the practice of medicine.

I must have medical evidence submitted to MPT, such as a letter from my treating physician, which includes diagnosis, prognosis and a statement that I am unable to perform any and every duty of my regular professional occupation. In addition, the letter must indicate the exact date of the disability and when the treating physician expects I will be able to return to work.

I understand that I will not be considered to be disabled by MPT until MPT approves my disability application. In order for my dues and assessments to be waived, and my obligation for Initial Trust Deposit (ITD) and claims co-payments (if any) to be temporarily suspended, I must be disabled for a minimum of 90 days. If this application for disability is not submitted to MPT within 90 days of the effective date of the disability, then I understand that assessment credits/refunds relating to a prior assessment year will not be granted. I understand that while I am on disability status, I will not be entitled professional liability coverage for any locum tenens who substitutes for me or my Entity (if applicable) to provide Professional Services to my patients.

I request disability status effective _____.
Month / Day / Year

I understand that, commencing the day after I last treated a patient until I am removed from disability status by MPT, I will not be entitled to professional liability protection services for any and all Claims based upon an Occurrence that takes place during my approved disability status.

I last treated a patient on _____.
Month / Day / Year

I understand that MPT will continue to provide professional liability protection services for Claims based upon an Occurrence that took place before the commencement of my approved disability status.

I understand that I must notify MPT when my disability ends and supply confirming

SAN DIEGO | ORANGE | LOS ANGELES | PALO ALTO | SACRAMENTO

COOPERATIVE OF AMERICAN PHYSICIANS, INC.

333 S. HOPE ST., 8TH FLOOR, LOS ANGELES, CA 90071 | PHONE 800-252-7706 | www.cap-mpt.com



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information from my treating physician that I am able to resume my regular professional occupation. I must receive written confirmation from MPT that I have been removed from my approved disability status and that my professional liability coverage has been reactivated before resuming my medical practice.

I understand that if this Application for Disability Status is approved, it shall be incorporated by this reference into the MPT Agreement.

I understand that it is my responsibility and I agree to notify all hospitals and other Health Facilities at which I have privileges of any changes in my professional liability coverage.

While I am on approved disability status, please mail all correspondence to:

Home Other _____

(_____) _____

This special application is deemed part of your membership in the Cooperative of American Physicians, Inc. (CAP) and your Entity's (if applicable) professional liability protection through MPT. If approved, it is incorporated into your MPT Agreement by this reference.

I warrant that the information contained in this application is true.

_____ Date _____
Member's Signature

FOR MPT USE ONLY

Approved _____ Effective date of status: _____
Declined _____ Acknowledged by: _____
MPT Representative