



COOPERATIVE OF  
AMERICAN PHYSICIANS

**APPLICATION FOR COVERAGE FOR NON-PRIVATE PRACTICE STATUS FOR MEMBERS AGE 58 AND OLDER THROUGH MUTUAL PROTECTION TRUST (MPT)**

**Physician Name:** \_\_\_\_\_

**Membership #:** \_\_\_\_\_

**Address and telephone number for all future communications:**

\_\_\_\_\_  
\_\_\_\_\_  
(       ) \_\_\_\_\_

I hereby request non-private practice status with MPT.

I have now totally ceased or will totally cease all private practice of medicine effective \_\_\_\_\_, 20\_\_\_\_. However, I will continue to perform professional medical services in a non-private practice where professional liability protection is provided by my employer.

I understand that to qualify for non-private practice status with MPT I must:

1. Totally cease the private practice of medicine;
2. Attain the age of fifty-eight (58);
3. Pay my Initial Trust Deposit (ITD) in full;
4. Pay the current year's dues and assessments as invoiced;
5. Have paid the fully matured assessment rate for 5 years if I am 58 or 4 years if I am 59 or 3 years if I am 60 to 64 years of age.
6. Provide proof of professional liability coverage for my non-private practice of medicine;
7. Practice medicine in any of the following situations:
  - a) Federal, state, county, or city government employment as the sole source of medical income
  - b) Military service
  - c) Faculty position
  - d) Public or charity funded clinic or facility providing services to the indigent.
  - e) Locum Tenens services exclusively as a contract physician.

I also understand that the following situations **do not** qualify for non-private practice



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status:

1. Employment with a medical group or private practice.
2. Employment relative to an HMO, such as Kaiser Permanente Medical Group, if I am seeing patients.
3. Employment in any capacity in which I am considered to be in private practice.

A description of my non-private medical practice, including name and location of my employer, follows:

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I understand that I am obligated to inform MPT in writing of any change in my practice, including my retirement from the practice of medicine.

*I also understand that I am obligated to notify and agree to notify all hospitals and other healthcare facilities at which I have privileges of any changes in my professional liability coverage.*

I understand that I am entitled to professional liability protection services as described in Part 1 of the MPT Agreement for Claims arising out of incidents during the Coverage Period up to and including the day prior to the effective date of my non-private practice status.

I understand that I am not entitled to professional liability protection services for any professional services rendered after the date I claim to have ceased the private practice of medicine. I also understand that I must inform MPT immediately if I decide to return to the private practice of medicine.

I acknowledge that my failure to immediately notify MPT of my return to the private practice of medicine may result in the loss of my coverage with MPT.

I understand that my current year's dues and assessments must be paid as invoiced until my request for non-private practice status is approved in writing. After my approval for non-private practice status, the prorated balance owed on my current year's assessments will be waived and I will be relieved of future assessments. I understand that I will continue to be liable for annual payments to CAP and MPT (currently \$495) after I am approved for non-private practice status until such time as my status is changed.

My Initial Trust Deposit shall remain on deposit as long as I am on non-private practice status.



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

***My signature on this application represents that I understand the terms and conditions of non-private practice status with MPT.***

I represent and warrant that the information contained in this application is true and understand the conditions of my non-private practice status with MPT. I agree to notify MPT promptly of any material change in the facts upon which my request is based.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**FOR MPT USE ONLY**

Approved \_\_\_\_\_ Effective Date of Status: \_\_\_\_\_

Declined \_\_\_\_\_ Acknowledged by: \_\_\_\_\_  
MPT Representative