



COOPERATIVE OF
AMERICAN PHYSICIANS

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

Physician Name: _____

Membership #: _____

Address and telephone number for all future communications:

(_____) _____

I hereby request retirement status with MPT. The last day I treated/will treat a patient is

month/day/year

I will be completely and fully retired from all practice of medicine, unless otherwise provided for herein, effective the following day.

I understand that in order to qualify for retirement status with MPT I must have:

- (1) attained the age of at least fifty-five (55);
- (2) paid my Initial Trust Deposit (ITD) in full;
- (3) a minimum of five years of continuous medical professional liability coverage, the most recent twelve months with MPT, if I am younger than 65 at the time I retire.

My date of birth is _____.
month/day/year

My signature on this application represents that I understand the terms and conditions of retirement status with MPT as follows:

MPT will not provide any professional liability coverage for any Professional Services rendered following the effective date of my retirement.

MPT will continue to provide me with the professional liability protection services described in Part 1 of the MPT Agreement for Claims arising out of Occurrences from the first date of my MPT membership (or retroactive coverage if applicable) up to and including the effective date of my retirement status.

While on retirement status I may provide professional services without being in violation of the terms and conditions of retirement status only under the following conditions:

- (1) If I practice medicine, I must work on a volunteer basis and not receive any remuneration.
- (2) I may review medical charts and records for attorneys, insurance companies, or other entities for remuneration.



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(3) I may perform independent medical examinations.

I will be relieved from assessments levied in the future.

If I have a Claims co-payment financial condition at the time retirement, that obligation will continue.

My Initial Trust Deposit (ITD) shall be repaid to me as provided for in the Mutual Protection Trust Agreement. It must be on deposit for at least 10 years before repayment can occur.

If at the time retirement status is granted to me, I have open Claims, my ITD shall not be refunded to me until all Claims which I have reported to MPT have been closed, or I attain the age of 65, whichever is sooner. I understand that during my retirement period while I have open Claims, the provision of Claims services on my behalf by MPT is dependent upon my full cooperation in the defense of said Claims.

It is my responsibility and I agree to notify all hospitals and other healthcare facilities at which I have privileges of any changes in my professional liability coverage.

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.

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

I understand that if this Application for Retirement 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