



COOPERATIVE OF
AMERICAN PHYSICIANS

**APPLICATION FOR RISK CLASSIFICATION REDUCTION COVERAGE
THROUGH MUTUAL PROTECTION TRUST (MPT)**

Physician Name: _____

Membership #: _____

I hereby request a reduction of my risk classification with MPT to correspond with a change in my professional practice. I have reduced or intend to reduce the scope of my professional practice effective:

Month/Day/Year

My prior professional practice consisted of:

My current or future professional practice consists or will consist of:

My signature on this application represents that I understand the terms and conditions of risk class reduction with MPT as follows:

Approval of my request for risk classification reduction will result in my assessments being impacted beginning with the year following my reduction in practice, as follows:

STANDARD RISK CLASS REDUCTION

- Year 1 Responsible for the assessment of the lower risk class plus 80% of the difference between the higher and lower risk class assessment rates.
- Year 2 Assessment of lower risk class + 60% of the difference
- Year 3 Assessment of lower risk class + 40% of the difference
- Year 4 Assessment of lower risk class + 20% of the difference
- Year 5 Assessment of lower risk class

For new members, credit for reduced practice prior to MPT membership may be applied in determining assessment level.

IMMEDIATE RISK CLASS REDUCTION

If I qualify for retirement status with MPT, have no open Claims, and request risk class reduction instead of retirement, I will be reduced to the lower risk classification rate beginning with the year following my reduction in practice. If I have open Claims, the regular risk class reduction program will apply until such time as all of my Claims are closed. I could then qualify for immediate risk class reduction the following January 1. If I am granted an

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

COOPERATIVE OF AMERICAN PHYSICIANS, INC.

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immediate reduction in my risk classification and then subsequently have a Claim asserted against me from the previous higher risk classification practice, I understand that I will be placed in the standard risk class reduction process at the level which otherwise would have been applicable to me had I not been granted the immediate reduction.

MPT will continue to provide me with the professional liability protection services as described in Part 1 of the MPT Agreement for Claims arising out of incidents from my previous scope of practice from the first date of my MPT membership (including retroactive coverage if applicable) up to the day prior to the effective date of my risk classification reduction status.

Any Claims arising out of or related to Professional Services rendered by me outside the scope of my reduced practice, as set forth in this application, shall be excluded from all professional liability coverage, including Claims defense and Claims payment services as described in Part 1 of the MPT Agreement. Such Claims may subject me to a hearing before the MPT Risk Assessment and Peer Review Committee and may jeopardize my membership in MPT.

I will not make further changes in the nature or scope of my current professional practice nor will I resume my prior professional practice without the prior written approval of MPT. 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.

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

Signature

Date

Print Name

FOR MPT USE ONLY

Effective Date of Practice Change: _____

Effective Date of Assessment Reduction: _____

From Risk Class: _____ Specialty: _____

To Risk Class: _____ Specialty: _____

Level of Assessment Reduction:

Year 1 ___ Year 2 ___ Year 3 ___ Year 4 ___ Year 5 ___

Approved by:

MPT Representative

Date