LIABILITY INSURANCE STATEMENT FOR OTHER HEALTH CARE PROVIDERS

DIVISION OF SPECIALIZED CARE FOR CHILDREN
3135 Old Jacksonville Road
Springfield, IL 62704-6488
Fax: (217) 558-0773
Toll Free: (877) 791-5170

STATEMENT CONCERNING LIABILITY INSURANCE

The Division of Specialized Care for Children (DSCC) requires that all providers providing services to DSCC clients maintain professional and general liability insurance.

I certify that this group/facility:

Maintain medical professional liability insurance in an amount not less than $1,000,000 per occurrence and an annual aggregate limit not less than $3,000,000 (or the limits of liability set by law in any state other than Illinois in which the group/facility practices)

Maintains Worker's Compensation (Part A) (including Occupational Diseases) as required in statutory limits and Employers Liability (Part B) in the amount of $500,000 per occurrence;

Maintains commercial general liability (including premises, products, completed operation, bodily injury or physical damage) in the amount of $1,000,000 per occurrence; *(if applicable)*

Maintains continuous coverage in the amount required by DSCC (or the state other than Illinois in which the group/facility practices) for the length of time providing services for DSCC clients;

OR

Agrees to purchase sufficient coverage (tail coverage) to include the services provided to DSCC clients if the group/facility's liability coverage is discontinued or reduced below the amounts noted above.

DSCC retains the right to modify insurance requirements from time to time and will notify providers of such changes. *Failure of DSCC to obtain proof of coverage shall not be deemed to be a waiver of the coverage requirement.*

You must send the following:

- ✔ Proof of professional liability coverage
- ✔ Proof of commercial general liability coverage *(if applicable)*

You must provide the following as applicable:

- ✔ Updated proof of coverage upon renewal
- ✔ Proof of tail coverage endorsement *(if applicable)*

Please complete, sign and date below:

Professional Liability Insurance Company______________________________

Policy Holder______________________ Policy Number______________________

Commercial Liability Insurance Company______________________________

Policy Holder______________________ Policy Number______________________

______________________ ______________________
Certifying Individual's Name (print or type) *Title*

______________________ ______________________
Signature of Certifying Individual *Date*