



PATIENTS COMPENSATION FUND ASSESSMENT
(OR EXEMPTION ON REVERSE SIDE)

State of Wisconsin
Office of the Commissioner of Insurance
Drawer 478
Milwaukee, WI 53293-0478

Account Number: 34831
Statement Date: 11/10/1999
Payment Must be Received By:

Please Pay Total Due:
or
Minimum Payment Due:

Please Print Any Address
Changes on Back

Sample

AMOUNT PAID

\$

C-1

OCI31-001 (R 05/99)

DETACH THIS PORTION AND RETURN WITH YOUR PAYMENT

INSTRUCTIONS: Pursuant to ch. 655, Wis. Stat., you must pay the amount due or complete reverse side to claim an exemption. You may pay the total due (with no interest) or the minimum payment due (with interest plus an administrative fee). Make your check payable to Commissioner of Insurance and send to Patients Compensation Fund, Drawer 478, Milwaukee, WI 53293-0478. Failure to pay your assessment will result in notice to your licensing board that you are in noncompliance, as provided in s. 655.23 (7), Wis. Stat.

JULIE L MITCHELL MD ACCOUNT NO. 34831 DATE: 11/10/1999

Dear Dr. Mitchell:

Our records indicate that there is currently no valid certificate of professional liability insurance filed with the WISCONSIN Patients Compensation Fund (Fund) on your behalf.

You are required under s. 601.42 (4), Wis. Stat., to take one of the following steps within 30 days of receiving this letter:

1. If you have professional liability insurance, contact your agent or insurance company to request that a certificate of insurance be filed with the Fund. Notify me in writing that you have done so, including the name of the person and insurance company you contacted.
2. If you are exempt from ch. 655, Wis. Stat., complete, sign, and return the EXEMPTION FORM ON THE REVERSE SIDE of this letter. Indicate the date your exempt status began and the basis for claiming the exemption (check one of the boxes, 1 through 8).
3. If you are subject to ch. 655, Wis. Stat., and do not have professional liability insurance, immediately arrange for insurance coverage for the period of your practice in Wisconsin. Notify me in writing that you have done so and provide the name of the agent or insurance company you contacted.

Please note that you do not have Fund coverage for any period during which you do not have primary professional liability insurance. In addition, the statutory limits of liability do not apply for any such period.

Thank you for your attention to this matter.

Sincerely,

Rodney K. Orr
Regulatory Specialist
Patients Compensation Fund
(608) 264-6227

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OCI31-001 (R 05/99)

Correct address is:

Attn:	P.O. Box or Street Address	
City	State	Zip + 4 (Required)

Sample

(Section 1)

Patients Compensation Fund Exemption

License # or Federal Employer # (FEIN)	NAME (Please Print)
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Instructions: If you are eligible and elect to exempt yourself, check **ONLY ONE** box below that best indicates your basis for your claimed exemption from mandatory provisions, benefits, and limitations in ch. 655, Wis. Stat. Provide effective date and sign form and return in enclosed envelope. You must complete all sections of the form for it to be valid. Personally identifiable information provided on this form will be used to update the Patients Compensation Fund data base, which is generally available to the public.

If you file an exemption for a period of time that you have previously been a Fund participant, i.e., had primary insurance coverage on file with the Fund and paid Fund assessments for same period, you **MUST** submit a written explanation.

(Section 2)

- 1. Effective _____ (M/D/YR), I will not practice in Wisconsin for more than 240 hours during a fiscal year. (July 1-June 30)
- 2. I am employed by the state, a county, or municipality. I will not practice outside that employment for more than 240 hours during a fiscal year (July 1-June 30). I claim this status effective _____ (M/D/YR).
- 3. I am a federal employe and covered under the Federal Tort Claims Act. I will not practice outside that employment for more than 240 hours during a fiscal year (July 1-June 30). I claim this status effective _____ (M/D/YR).
- 5. My principal place of practice is not Wisconsin. Effective _____ (M/D/YR), more than 50% of the income from my practice will be derived from outside Wisconsin or I will render services to more than 50% of my patients outside Wisconsin during a fiscal year (July 1-June 30).
- 6. Retired from or discontinued all medical practice in Wisconsin that requires a medical license as of _____ (M/D/YR).
- 7. I am licensed in Wisconsin but have not practiced in the state to date, or did not practice in the state from _____ (M/D/YR) to _____ (M/D/YR). The grant date of my Wisconsin license is _____ (M/D/YR).
- 8. This corporation/partnership/facility is no longer providing medical services in Wisconsin as of _____ (M/D/YR).
- 9. Effective _____ (M/D/YR) through _____ (M/D/YR) I will be temporarily ceasing practice for more than 90 consecutive days. If I do not know the effective date of my restarting practice, I must notify the Fund in writing of my return date.

I understand that if I claim an exemption, I will not have the protection of the Patients Compensation Fund. My status with the Fund will remain as reported above unless or until I, or an insurance carrier on my behalf, notify the Fund in writing, or through electronic filing, of a change in my status.

Signature	Telephone Number	Date Signed
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