

**LOUISIANA PATIENT'S COMPENSATION FUND
CORPORATION APPLICATION
(for those with underlying self-insurance and primary insurance)**

For those with primary insurance, please provide a copy of the COI or declarations page from the insurer's policy evidencing coverage for the corporation.

DATE

SIGNATURE OF AUTHORIZED REPRESENTATIVE

CONTACT PERSON AND PHONE #:

CONTACT EMAIL ADDRESS:

After form has been completed, printed and signed, please mail or fax to:

**LOUISIANA PATIENT'S COMPENSATION FUND
SURCHARGE DEPARTMENT
P. O. BOX 3718
BATON ROUGE, LA 70821
PHONE #: (866) 469-9555
FAX: (225) 342-5593**

Any questions regarding this form may be emailed to:
pcf-surcharge@la.gov

**A PRINTED, SIGNED COPY OF THIS FORM MUST
BE MAILED/FAXED TO PCF.**