



COOPERATIVE OF  
AMERICAN PHYSICIANS

**APPLICATION FOR CESSATION OF PRACTICE STATUS WITH  
MUTUAL PROTECTION TRUST (MPT)**

Physician Name: \_\_\_\_\_

Membership # (if Member): \_\_\_\_\_

I hereby request cessation of practice status with MPT. I have completely and fully ceased or will cease all practice of medicine, unless otherwise provided for herein, effective 12:00 midnight on

\_\_\_\_\_. I last treated a patient or will last treat a patient on \_\_\_\_\_.  
month/day/year. month/day/year

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

In order to qualify for cessation of practice status with MPT I must have:

- (1) have ceased the practice of medicine
- (1) be between the ages of fifty-five (55) and fifty-seven (57)
- (2) have been a member of Cooperative of American Physicians, Inc. (CAP) for at least 8 years.

My date of birth is \_\_\_\_\_.  
month/day/year

MPT will not provide any professional liability coverage for any Professional Services rendered following the effective date of my Cessation of Practice status. MPT will continue to provide me with the professional liability protection services described in Article VIII 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 day prior to the effective date of my Cessation of Practice status.

If I should decide to return to the practice of medicine, I must inform MPT immediately. *Failure to do so may result in loss of my tail coverage with MPT.* Coverage for any resumed practice of medicine shall not commence until approval of my status changed to Active status is granted by MPT.

While I am on Cessation of Practice Status, I may provide professional services without being in violation of the terms and conditions of Cessation of Practice *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 and insurance companies for remuneration.
- 3) I may perform independent medical examinations.

Rev. 08/07

SAN DIEGO | ORANGE | LOS ANGELES | SAN JOSE | SACRAMENTO

COOPERATIVE OF AMERICAN PHYSICIANS, INC.

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While I am on cessation of practice status (ages 55 - 57), I will continue to pay annual dues and assessments as billed. Commencing the first year after my approval for cessation of practice status, my assessment will be:

Year 1	reduced by 25%;
Year 2	by 65%;
Year 3	by 90%;

My Initial Trust Deposit shall remain on deposit as long as I am on cessation of practice status.

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.

Upon reaching age 58, my CAP membership status will automatically be changed to retirement status. All terms and conditions applicable to cessation of practice status will also apply to retirement status except those that relate to my dues, assessments, and Initial Trust Deposit. The financial conditions applicable to retirement status are as follows:

- I will be relieved from assessments levied in the future, and the assessment I am paying or have paid in the year that I retire will be prorated based upon my retirement date.
- 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.

I warrant that the information contained in this application is true and understand the conditions of my cessation of practice status and subsequent 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 this Application for Cessation of Practice Status is deemed part of my membership in CAP and professional liability protection through MPT. If approved, it is incorporated into such by this reference and incorporated by this reference into the MPT Agreement

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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Please indicate address and telephone number for all future communications:

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FOR MPT USE ONLY

Approved \_\_\_\_\_

Effective Date of Status: \_\_\_\_\_

Declined \_\_\_\_\_

Acknowledged by: \_\_\_\_\_  
MPT Representative