



**APPLICANT INFORMATION**

Applicant Name	Policy Number or Professional License Number
<b>THIS FORM SUPPLEMENTS INFORMATION CONTAINED IN YOUR INDIVIDUAL PROFESSIONAL LIABILITY POLICY APPLICATION. USE IT TO APPLY FOR A REDUCTION IN STANDARD POLICY COVERAGE AND PREMIUM.</b>	<b>Producer Name and Code</b> <i>(To be completed by Agent or Broker only)</i>

**ELIGIBILITY**

Part-time practice discounts are available to health care professionals who meet the Company's standards, rules and criteria for a structured part-time practice. In calculating your practice hours, the Company's standards and rules require, among other things, that we include travel time related to your practice and time spent for meals and other customary breaks from your practice.

**REASON FOR PART-TIME PRACTICE COVERAGE/PRACTICE DESCRIPTION**

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**HOURS IN THE PRACTICE OF MEDICINE**

I. Your posted office hours for all offices (i.e., 2:00 p.m. to 5:00 p.m.):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

II. List the number of hours per week that you spend in your practice or in other medically related activities **outside** of posted office hours and describe these activities. You must include all time spent treating patients in hospitals, clinics, surgery centers, or other health care facilities, scheduled on-call hours, consulting, attending rounds and meetings, charting treatment and performing any other medically related activities.

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III. If your request for the part-time practice discount is a result of being affiliated with a health care provider/professional organization providing malpractice coverage on your behalf for some portion of your primary practice, please list and describe this arrangement and the time involved.

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*In consideration of a reduced premium, I request that my Professional Liability Insurance Policy be restricted by attachment of a Part-Time Practice Limitation Endorsement. I have read and understand the provisions of this endorsement, a facsimile of which is reproduced on the reverse of this application.*

*I certify (and warrant where permitted by law to do so) that the information contained in this application and any supplements or additional documents is complete and true. I understand that all the facts stated herein are material and that they form the basis for the issuance of the part-time discount by the Company. I also understand that this application is subject to acceptance by the Company and does not bind coverage, that, where permitted by law, it will be made part of any policy issued to me, and that any misrepresentation or omission of material facts will void the policy.*

*I hereby authorize any hospital, health care provider, medical association or society, board of medical examiners, governmental agency, insurance carrier, attorney, or any other person or entity having such information to release to the company any information, which in the Company's judgment may have a bearing on my application for a part-time discount. I hereby release and agree to hold harmless any releasing party, its agents, servants and employees, as well as the Company, its directors, officers, employees or agents, from any liability arising out of the release or use of the released information notwithstanding that there may be errors or omissions in such information.*


**SIGNATURE**

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Applicant's/Insured's Signature	Date	Proposed Effective Date
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**ENDORSEMENT FACSIMILE**

▪ THIS IS AN ILLUSTRATION OF THE ACTUAL ENDORSEMENT THAT WILL BE ATTACHED TO YOUR POLICY ▪

<b>Insurance is provided by:</b>		<b>LIMITATION PART-TIME PRACTICE</b>	
			
Date Issued:		Effective Date:	
POLICY NUMBER	POLICY PERIOD	CUSTOMER NUMBER	PRODUCER CODE
	TO *		
* 12:01 A.M. Standard time at the Named Insured's mailing address designated in the Declarations.			
<b>This form modifies insurance provided under the following:</b>			
<ul style="list-style-type: none"> <li>• All Coverage Forms</li> </ul>			
<p>It is a Condition of this insurance that professional practice of the insured listed in the Schedule below for which the policy provides coverage, will be limited to less than the number of hours per week designated below. If the number of hours in which such insured engages in practice changes during the term of the policy, you must notify us as soon as practicable. We will then be entitled to an additional premium charge from the date of the change. This premium charge will be based on our rules and rates in effect at the inception date of the policy.</p>			
<b>SCHEDULE:</b>			
<u>Name</u>		<u>Hours Per Week</u>	

▪ THIS IS AN ILLUSTRATION OF THE ACTUAL ENDORSEMENT THAT WILL BE ATTACHED TO YOUR POLICY ▪