

APPLICANT INFORMATION

Applicant Name	Policy Number or Professional License Number
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.	Producer Name and Code (To be completed by Agent or Broker only)

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

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.

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.

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

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 •

Insurance is provided by:		LIMITATION PART-TIME PRACTICE	
Medical Mutual Liability Insurance Society of Maryland Home Office: 225 International Circle, Box 8016 Hunt Valley, MD 21030		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.			
This form modifies insurance provided under the following:			
<ul style="list-style-type: none"> • All Coverage Forms 			
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.			
SCHEDULE:			
<u>Name</u>			<u>Hours Per Week</u>
Form MM 40042 0102			Page _ of _

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PART-TIME APPLICATION INSTRUCTIONS

(Major Surgery – not applicable)

I understand that you would like to apply for a part-time discount. If your hours are not more than 19 per week you may be eligible for a 50% part-time discount. If your hours are more than 19 hours but less than 30 hours you may be eligible for a 25% part-time discount. Please be advised that in order for Medical Mutual to consider you for a part-time discount, please complete that attached part-time application with ***additional*** instructions as follows:

There must be an ***“approved” reason for part-time practice***, such as, other employment, semi-retirement, health reasons or pregnancy/small children.

I. Please include all scheduled time spent in the office *including but not limited to* the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Treating patients | <input type="checkbox"/> Lunch time | <input type="checkbox"/> Updating patient charts |
| <input type="checkbox"/> Writing prescriptions | <input type="checkbox"/> Telephone consultations | <input type="checkbox"/> Reviewing test results |

I. Include any other time engaged in the practice of medicine that is not included in Section I, *including but not limited to* the following:

- | | |
|--|---|
| <input type="checkbox"/> Scheduled on call hours | <input type="checkbox"/> Availability to be reached by patients after hours |
| <input type="checkbox"/> Consulting (In person or telephone) | <input type="checkbox"/> Transportation time |
| <input type="checkbox"/> Attending rounds/meetings | <input type="checkbox"/> Treating Patients in any healthcare facility |
| <input type="checkbox"/> Charting, prescribing, performing/reviewing tests | <input type="checkbox"/> Any other medically related activities |

II. If you have other employment, that is insured elsewhere, please list the employer here to be excluded from this policy. Please also list the weekly schedule/hours for this work to allow the carrier to determine if it is significant enough to warrant an approved reason for other employment.

If a part-time discount is maintained on a policy for the three immediate preceding years prior to policy cancellation, it can be applied toward the TAIL upon underwriting approval. If the percentage changes, during that time, the lower discount or no discount will be applied.

Please keep in mind, Medical Mutual does not back date coverage, therefore, please submit all requests on or before the desired effective date by fax, or, if time allows, by mail. If you should have any questions, please do not hesitate to contact us at 1-800-543-1262.