



PART-TIME OR LIMITED EXPOSURE QUESTIONNAIRE

(Please TYPE or PRINT in black ink.)

Name: _____

Address: _____

Telephone Number: () _____

This form may be a supplement to your application, Current Practice Profile, or sent as a separate questionnaire. The purpose of the questionnaire is to determine and document your eligibility for a premium discount for a part-time or limited practice exposure covered by the Company.

A part-time or limited practice exposure is defined as a practice of medicine totaling an average of thirty (30) hours or less per week. The determination of the number of practice hours for which the Company provides coverage shall include an average of all office hours and hospital hours.

The application of this premium discount shall be in strict accordance with the Company's Part-Time or Limited Practice Exposure program. Please respond to the following questions in order that we may determine your eligibility for the applicable discount. **Return the signed and dated form to the Company with your application or in the enclosed pre-paid envelope within ten (10) days.**

1. Identify which of the following describes your present situation (check the appropriate category):

a. Semi-retired due to age.
Date of birth: _____ Date of retirement: _____

b. Semi-retired due to health.
If so, describe health condition that caused you to reduce your practice.

c. Practice full-time, but present only a limited exposure to the Company. Under this situation, the Company provides coverage for moonlighting only outside my primary practice of medicine. Identify which applies:

Residency or Fellowship program.
Name & location of program _____

Military service or Federal Government agency.
Branch & location _____

Other--Please explain _____

- d. Other situation not described above. Please explain, including name of employer and location. _____

2. Indicate the average number of hours per week devoted to each of the following **for which the Company is to provide coverage.**

NOTE: Your response will determine eligibility and amount of discount applied.

- a. Office Practice = _____ hours
b. Hospital Practice = _____ hours
c. Emergency Room = _____ hours
d. Other--please explain:
_____ = _____ hours

I hereby represent the truth of my statements and reasons mentioned herein, and that I have not withheld any information which is likely to influence the judgment of the Company in considering the application of the described discount to the premium charged for my professional liability coverage. I understand that the Company may inquire of my practice situation at any time to determine my acceptability for continuation of this premium discount. I agree to notify the Company of any future changes in my practice related to the information supplied in this questionnaire.

Signature of Physician

Date of Signature