

# PART-TIME OR LIMITED EXPOSURE QUESTIONNAIRE

- Medical Mutual Insurance Company of North Carolina
- Medical Security Insurance Company  
(hereinafter referred to as the "Company")

*(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