



Part-time Application

Name Insured: _____

Agency Name: _____ Policy Number: _____

Effective date of change: _____

1. List all locations where you work (mail will be sent to the first address unless indicated otherwise).

	Street	City	County	State	Zip	Phone #
(1)	_____	_____	_____	_____	_____	_____
(2)	_____	_____	_____	_____	_____	_____
(3)	_____	_____	_____	_____	_____	_____
(4)	_____	_____	_____	_____	_____	_____

2. Please indicate total hours per week and month devoted to the following activities at each location:

	Loc. (1)		Loc. (2)		Loc. (3)		Loc. (4)	
	Wk	Mo	Wk	Mo	Wk	Mo	Wk	Mo
a. Actual patient care including recordkeeping and hospital rounds								
b. Office hours								
c. Administrative duties								
d. Surgeries and assists								
e. House calls and nursing home visits								
f. Utilization Review								
g. Total Practice Hours								

3. Please provide a detailed description of how your practice has changed: _____

4. Please advise the reason your practice has changed from full-time to part-time. _____

5. How long do you anticipate practicing on a part-time basis? _____

6. If you are a member of a corporation or partnership, how has your membership status changed? _____

Signature of Applicant: _____ Date: _____

Part-time rate is subject to Company approval.

All questions must be answered for part-time rate to be considered.