

**This is an Application for Claims-made Coverage**

**PART-TIME /SEMI-RETIRED PHYSICIAN APPLICATION**

Applicant: \_\_\_\_\_

Current Policy#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

1) Do you have a full-time practice? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe. \_\_\_\_\_

Do you need insurance coverage from MAG Mutual for your full-time practice?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If not, who is providing this coverage for you? (Attach proof of insurance)  
\_\_\_\_\_

2) Do you have a part-time practice? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe. \_\_\_\_\_

Do you need insurance coverage from MAG Mutual for your part-time practice?  
Yes \_\_\_\_\_ No \_\_\_\_\_

3) How long have you been practicing in the manner described in #2 above?  
\_\_\_\_\_

- 4) Do you practice as:
- a. a teaching physician? Yes \_\_\_\_\_ No \_\_\_\_\_
  - b. a physician moonlighting outside an accredited, post graduate educational program. Yes \_\_\_\_\_ No \_\_\_\_\_
  - c. a semi-retired physician Yes \_\_\_\_\_ No \_\_\_\_\_
  - d. a physician moonlighting outside a full-time practice which is separately insured. Yes \_\_\_\_\_ No \_\_\_\_\_
  - e. a physician only practicing medicine on a part-time basis. Yes \_\_\_\_\_ No \_\_\_\_\_
  - f. other (please describe) \_\_\_\_\_

5) Please list the maximums per month for the following duties to be covered under part-time policy:

- Hospital rounds \_\_\_\_\_ hrs/month
- Office practice (including completing charts and consulting) \_\_\_\_\_ hrs/month
- Emergency Room \_\_\_\_\_ hrs/month
- On-Call emergencies \_\_\_\_\_ hrs/month
- Administration of anesthesia \_\_\_\_\_ hrs/month
- Major surgeries \_\_\_\_\_ # procedures/month
- Minor surgeries (exclusive of suturing lacerations, I&D) \_\_\_\_\_ # procedures/month
- All surgeries \_\_\_\_\_ # procedures/month
- Deliveries \_\_\_\_\_ # procedures/month

6) Please list all hospitals at which you currently hold privileges.

<u>HOSPITAL and CITY</u>	<u>ACTIVE PRIVILEGES</u>	<u>COURTESY PRIVILEGES</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby declare that the information provided in this Questionnaire is true and complete to the best of my belief, knowledge and recollection and that I have not willfully concealed or misrepresented any material facts or circumstances. I also declare that I will notify MAG Mutual Insurance Company in writing if the maximum hours or numbers stated in Question 5 above increase during the policy period.

If approved for a part-time rate, I understand that the policy will contain a Restrictive Endorsement providing for a \$5,000 Each loss deductible if there is evidence that I have exceeded the maximum number of hours and/ procedures declared.

\_\_\_\_\_  
Signature (Required)

\_\_\_\_\_  
Date