Limited Scope of Coverage/Part-Time Application Addendum

☐ ProSelect Insurance Company
☐ Medical Professional Mutual Insurance Company

PART I - APPLICANT INFORMATION			
First Name	Middle Initial	Last Name	Policy Number

Failure to return this practice addendum by the effective date of this policy will result in loss of credit for the policy period

PART II – GENERAL QUESTIONS

Hospitals at which you have admitting privileges:

Where is your primary place of clinical practice?	How many hours per week do you work at your primary place of practice?	Who is the Insurer of your primary practice?

Please list all locations of your Medical Practice Activities:

Location	Specialty/ Activities	# Hours per week in direct patient care**	Do you have current coverage?	Insurance Carrier*	Are you requesting coverage for this location?
1.			☐ Yes ☐ No		☐ Yes ☐ No
2.			☐ Yes ☐ No		☐ Yes ☐ No
3.			☐ Yes ☐ No		☐ Yes ☐ No
4.			☐ Yes ☐ No		☐ Yes ☐ No
5.			☐ Yes ☐ No		☐ Yes ☐ No
6.			☐ Yes ☐ No		☐ Yes ☐ No
7.			☐ Yes ☐ No		☐ Yes ☐ No
8.			☐ Yes ☐ No		☐ Yes ☐ No

If practicing part time, when did you begin practicing a total of 20 hours or less per week or 80 hours or less per month? Mo. Yr.

If you are a Resident or Fellow, you must include a letter from your program director allowing you to practice outside of the Residency/Fellowship Program.

***Please attach a copy of your declarations page from your current primary insurer.**

PART III – DEFINITION DIRECT PATIENT CARE

** Direct Patient Care:
Eligibility for the Part Time Credit will be based upon the number of hours of Direct Patient Care engaged in by the insured.

"Direct Patient Care" is defined as any activity that could form the basis for the assertion of a professional liability claim by a patient against the insured. Direct Patient Care includes the activities listed below, whether occurring during the course of the insured's office practice, outpatient hospital practice, clinical practice, in-patient hospital practice (including but not limited to attending duties), specialty consultation, on-call time (including any telephone consultation), or any patient follow-up:

a. examining or testing the patient;
b. making or consulting in the diagnosis of the patient's medical or dental condition;
c. performing any medical or dental procedures on the patient;
d. prescribing any medication or medical or dental treatment for the patient;
e. dictating, updating, or reviewing medical records;
f. making rounds on patients;
g. consulting with or writing to the patient, the patient's relatives or representatives, a referring physician or dentist or a consulting physician or dentist concerning the patient's medical or dental care and treatment;
h. consulting with, observing or supervising members of the healthcare staff, including residents, nurses, assistants, hygienists and any other healthcare personnel responsible for the patient's medical or dental care, with respect to the patient's medical or dental care and treatment.

It is understood and agreed that the foregoing guidelines do not necessarily include an exhaustive list of direct patient care activities. Accordingly, any activities which the insured has reason to believe could form the legal basis for a professional liability claim, whether or not such activities are specifically set forth in the foregoing guidelines, are included as direct patient care activities.

PART IV – TERMS AND CONDITIONS

Part Time Credit:

I hereby apply for Part Time Practice Credit from the regular premium for my medical malpractice insurance policy to be issued by Rockwood. In making this application, I certify the following:

1. I will **not** spend more than the designated hours listed above for the exposure to be covered by Rockwood in direct patient care.

2. I will maintain an unrestricted license to practice medicine/dentistry.

3. I agree to maintain accurate records recording the number of hours spent by me in direct patient care and to allow the Company to audit those records on-site during reasonable business hours and without prior notice or approval, provided that such an on-site audit does not unnecessarily interfere with the operation of my practice.

4. I agree to report any change in the nature of my practice which may affect my eligibility for a Limited Practice Credit to the Underwriting Department of the Company as soon as any such change occurs.

5. I understand that if I exceed the maximum number of hours in direct patient care or otherwise fail to comply with the requirements for this credit, the Company may revoke the credit and I will be required to refund the amount of the credit for any policy year for which non-compliance is found within thirty (30) days or my policy will be cancelled for non-payment of premium.* I further understand that if I lose my credit for non-compliance with the requirements, I will be ineligible for a further credit for a minimum of two (2) policy years following such revocation, and in no event will I be eligible for a further credit unless I satisfy the Company that I have complied with the requirements for the credit.

APPLICANT SIGNATURE			
Please sign below. An additional signature is required on the State Disclosure Addendum. Your application is not complete without both signatures.			
Signature	*Printed Name*	*Title*	*Date*