

# APPLICATION FOR RATE DISCOUNT: PART-TIME PRACTICE

*(An application is required at each renewal)*

Name: \_\_\_\_\_

License No.: \_\_\_\_\_

## Complete the following questions to verify eligibility:

- \_\_\_\_\_ 1. Approximate practice hours per year. This is the time you spend in patient care (including hospital rounds, completion of patient medical records, and consultations).
- \_\_\_\_\_ 2. When did you begin practicing 1000 hours per year, or less?
- \_\_\_\_\_ 3. Do you expect to continue the reduced practice for at least the next year?

I certify that the above information is true and correct, to the best of my knowledge. I will notify the company immediately if there is any change in my practice activity.

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
*(Insured)*

## Summary of General Requirements:

1. Practice does not exceed 1000 hours per year.
2. Part-time status must be permanent, or of long-term duration, except for pregnancy.

## Summary of General Rules:

1. Eligibility is subject to Company approval in all cases.
2. Annual verification is required.
3. Special documentation may be requested.

