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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