Form G – REQUEST FOR PART-TIME COVERAGE

Please complete this form if you are requesting coverage for working part-time.

1. Name: _____ □ M.D. □ D.O. □ Other

2. Physicians Standard Insurance Company Policy # (if applicable): _____

3. I am requesting coverage on a part-time basis effective (mm/dd/yy): ____/____/____

4. Number of hours worked per week for which coverage is being requested (Practice hours consist of: hospital rounds, on call hours involving patient contact, communications with other physicians, patient visits, and charting.): _____

5. Patient Load per Week: _____

6. Specialty for which you are applying for coverage: _____

7. My practice is reduced due to:

□ Pregnancy or dependent care

□ Semi-retirement: Date of Birth: ____/____/____

□ Disability: Type _____ (Please submit explanation from treating physician)

□ Majority of time spent in a teaching capacity – Hours per week: _____ Place: _____

□ Majority of employment insured through hospital: Name of Hospital: _____

□ Majority of employment is in another state, which is insured elsewhere; State: ____

□ Majority of practice insured through another carrier, entity or employer.

□ Other (Please provide a description) _____

8. How long do you anticipate your coverage will be at these reduced hours? _____

9. Please submit proof of coverage for any employment listed above which is to be excluded on your Physicians Standard Insurance Company Policy.

Signature _____ Date ____/____/____