MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

P.O. Box 1287, Latham, NY 12110
(800) ASK-MLMIC | MLMIC.com
New York City | Long Island | Colonie | Syracuse | Buffalo

Supplemental Application for Physician and Surgeon Part-Time Insurance Coverage

1. Name of Applicant: _____ 2. Date of Birth: _____
Month / Day / Year

3. What is your Specialty? _____

4. Requesting Part-Time Coverage Effective: _____
Month / Day / Year

All applications are subject to approval. If your application is approved, coverage can be provided no earlier than the day following receipt of the information. A premium discount will be provided to qualified physicians whose total practice to be covered under a MLMIC policy will not exceed twenty (20) hours in any given week.

5. Please outline all of your Professional Activities below. Professional Activities include patient care, record keeping, consultation, supervision of healthcare professionals, on call, volunteer work, hospital rounds, accreditation, and other review functions on behalf of a hospital or professional society, even if covered by other insurance.

TOTAL Hours By Day of Week

	In Office	In Hospital	Other – Facility, Agency, Employer	(a) On-Call	Name of Hospital, Facility, Agency and/or Employer	Hours to be covered by: (b) MLMIC	Hours to be covered by: (c) OTHER	Total Hours
Sun.								
Mon.								
Tue.								
Wed.								
Thur.								
Fri.								
Sat.								

(a) Of the hours listed under On-Call in the grid above, how many hours per week, on average, are spent treating patients in person or by consultation for which you require coverage under an individual MLMIC policy: _____

(b) Of the total hours in the grid above, state how many hours and describe all activities for which you require coverage under an individual MLMIC policy? _____ Hours per week covered by a MLMIC policy.

Activities: _____

_____

(c) Of the total hours listed in the grid above, how many hours are, or will be, covered by other insurance and not by your individual MLMIC policy? _____ Hours per week covered by other insurance. (If none, indicate "0".)

Describe all activities covered by other insurance and name of the insurance company(ies).

_____

_____

Note:

(1) As a condition for a reduced rate of premium, an endorsement will be attached to your policy excluding coverage for the activities listed in (c) above.
(2) The hours indicated in 5 (a), (b), and (c) above should equal the "Total Hours" column in the grid.
(3) If the total of (a) and (b) is greater than twenty (20), you do not qualify for part-time coverage.

(d) For all activities to be covered by MLMIC, as described in 5 (b), please complete the grid below by indicating the **Maximum Number** for each **Professional Service** you will provide in any given week, the **Total Hours Per Week** associated with each **Professional Service**, and the **Percentage of Time for Follow-up Care**. If a **Professional Service** does not apply, please indicate N/A.

	Professional Service	**Maximum Number**	**Total Hours Per Week**	**Percentage of Time for Follow-up Care**
1.	Patients seen during office hours or at a hospital			
2.	Obstetrical Deliveries			
3.	Radiology films interpreted			
4.	Minor surgical procedures performed			
5.	Major surgical procedures performed			

(e) If applicable, indicate the specific types of Minor and Major surgical procedures performed.

Minor Surgical Procedures	Major Surgical Procedures

6. A reduced premium rate is conditioned upon an endorsement being attached to your policy excluding coverage for all activities described in 5 (c). The following restrictive language will be included in your policy.

PART-TIME ENDORSEMENT

It is agreed that, in reliance upon the Insured's written declarations and representation and in consideration of the reduced rate of Premium at which this policy is written, the Insured's part-time practice to be covered will not exceed twenty (20) hours weekly.

No insurance is provided for the Insured's other medical practice activity that is covered by insurance issued by another company.

As a further condition for a reduced premium, I herein consent to an audit of my records to substantiate the limited hours of practice to be covered by MLMIC insurance.

DATE SIGNATURE

NEW YORK STATE INSURANCE DEPARTMENT REGULATION DECLARES THAT:
"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

DATE SIGNATURE