

## Supplemental Part-Time Application Physician and Surgeon

Please return the completed application to [apply@mlmic.com](mailto:apply@mlmic.com) or fax (212) 576-9877

1. Name of Applicant: \_\_\_\_\_ 2. Medical License #: \_\_\_\_\_

3. 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 an average of twenty (20) hours weekly, for a maximum aggregate of eighty-eight (88) hours per month.**

4. Total hours treating patients/professional activities that require MLMIC coverage:

Average Per Week: \_\_\_\_ and Maximum Per Month: \_\_\_\_

*\*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.*

5. Please describe your hourly and monthly practice schedule:

6. Do you provide any professional medical services that do NOT require coverage under your MLMIC policy? \_\_\_\_ Yes\* \_\_\_\_ No

\*If Yes: (a.) Name of hospital, facility, Agency, or Employer: \_\_\_\_\_

(b.) Professional Liability Insurance Company: \_\_\_\_\_

7. A reduced premium rate is conditioned upon an endorsement being attached to your policy excluding coverage for all activities described in 6 above. 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 an average of twenty (20) hours weekly, for a maximum aggregate of eighty-eight (88) hours per month.

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.

### 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.”

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date