Limited Practice Credit
Addendum

- ☐ Medical Professional Mutual Insurance Company
- ☐ ProSelect Insurance Company
- ☐ ProSelect National Insurance Company, Inc.

First Name	Middle Initial	Last Name	Policy Number

Failure to return this credit application by the effective date of this policy will result in loss of credit for the policy period.

Hospitals at which the member has admitting privileges:

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Average Direct Patient Care Hours per week _______________

Average Total Hours of Work per week _______________
(including direct patient care hours and other professional activities such as teaching, research, and administrative activities)

OR

Average Direct Patient Care Hours per month _______________

Average Total Hours of Work per month _______________
(including direct patient care hours and other professional activities such as teaching, research, and administrative activities)

When did you begin practicing 21 hours or less per week or 80 hours or less per month? month_________ year_____________

Eligibility for the credit will be based upon the number of hours of direct patient care engaged in by the insured. “Direct patient care” is defined as any activity that could form the basis for the assertion of a professional liability claim by a patient against the insured. Direct patient care includes the activities listed below, whether occurring during the course of the insured’s office practice, outpatient hospital practice, clinical practice, in-patient hospital practice (including but not limited to attending duties), specialty consultation, on-call time (including any telephone consultation), or any patient follow-up:

a. examining or testing the patient;
b. making or consulting in the diagnosis of the patient’s medical or dental condition;
c. performing any medical or dental procedures on the patient;
d. prescribing any medication or medical or dental treatment for the patient;
e. dictating, updating, or reviewing medical records;
f. making rounds on patients;
g. consulting with or writing to the patient, the patient’s relatives or representatives, a referring physician or dentist or a consulting physician or dentist concerning the patient’s medical or dental care and treatment;
h. consulting with, observing or supervising members of the healthcare staff, including residents, nurses, assistants, hygienists and any other healthcare personnel responsible for the patient’s medical or dental care, with respect to the patient’s medical or dental care and treatment.

It is understood and agreed that the foregoing guidelines do not necessarily include an exhaustive list of direct patient care activities. Accordingly, any activities which the insured has reason to believe could form the legal basis for a professional liability claim, whether or not such activities are specifically set forth in the foregoing guidelines, are included as direct patient care activities.

TERMS AND CONDITIONS

I hereby apply for the Limited Practice Credit from the regular premium for my medical malpractice insurance policy to be issued by Coverys. In making this application, I certify the following:

1. I will **not** spend more than 21 hours per week or 80 hours per month, involved in direct patient care.

(continued on the reverse side)

TERMS AND CONDITIONS (continued)

2. I will maintain an unrestricted license to practice medicine/dentistry.

3. I agree to maintain accurate records recording the number of hours spent by me in direct patient care and to allow the Company to audit those records on-site during reasonable business hours and without prior notice or approval, provided that such an on-site audit does not unnecessarily interfere with the operation of my practice.

4. I agree to report any change in the nature of my practice which may affect my eligibility for a Limited Practice Credit to the Underwriting Department of the Company as soon as any such change occurs.

5. I understand that if I exceed the maximum number of hours in direct patient care or otherwise fail to comply with the requirements for this credit, the Company may revoke the credit and I will be required to refund the amount of the credit for any policy year for which non-compliance is found within thirty (30) days or my policy will be cancelled for non-payment of premium.* I further understand that if I lose my credit for non-compliance with the requirements, I will be ineligible for a further credit for a minimum of two (2) policy years following such revocation, and in no event will I be eligible for a further credit unless I satisfy the Company that I have complied with the requirements for the credit.

I HEREBY CERTIFY UNDER THE PAINS AND PENALTIES OF PERJURY THAT THE FOREGOING REPRESENTATIONS ARE TRUE AND THAT THEY ARE MADE BY ME IN ORDER TO RECEIVE A CREDIT ON MY OTHERWISE APPLICABLE PREMIUM FOR PROFESSIONAL LIABILITY INSURANCE COVERAGE.

MARYLAND APPLICANTS: WE ARE NOTIFYING YOU THAT THE BINDER OR POLICY YOU HAVE JUST AGREED TO PURCHASE IS SUBJECT TO A 45 DAY UNDERWRITING PERIOD BEGINNING ON THE EFFECTIVE DATE OF YOUR COVERAGE. YOUR COVERAGE MAY BE CANCELLED DURING THE UNDERWRITING PERIOD IF YOUR RISK DOES NOT MEET OUR UNDERWRITING STANDARDS. IF WE DECIDE TO CANCEL THE BINDER OR POLICY, WE WILL SEND YOU A WRITTEN NOTICE OF CANCELLATION ADVISING YOU THE REASON(S) FOR THE CANCELLATION AND THE DATE ON WHICH YOUR POLICY WILL BE CANCELLED.

ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NEW HAMPSHIRE APPLICANTS: IF YOU REFUSE TO REFUND THE AMOUNT OF THE CREDIT FOR ANY POLICY YEAR FOR WHICH NON-COMPLIANCE IS FOUND, THE COMPANY WILL CONSIDER THE REFUSAL NON-COMPLIANCE WITH POLICY CONDITIONS AND WILL CANCEL THE POLICY ON SUCH GROUNDS

Signature of Applicant ______________________ Title ______________________

Printed Name ______________________ Date ______________________

Signature of Producer *(signature is required for N.H. producers only)* ______________________ Date ______________________

Printed Name of Producer ______________________