COVERYS®

Moonlighter Credit Addendum

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

First Name/Corporate Name	Middle Initial	Last Name	Policy Number

In order to receive a moonlighting credit, please complete the following questionnaire for our records. This questionnaire will become part of your malpractice insurance application, and as such, all provisions of your malpractice insurance application will apply to this questionnaire.
Failure to return this credit application by the effective date of this policy will result in loss of credit for the policy period.

Where is your primary place of clinical practice?

How many hours per week do you work at your primary place of clinical practice?

Who is the insurer of your primary practice?

Please complete the following based on your moonlighting activity:

Location	Specialty/Activities	# Hours per Week
1:		
2:		
3:		

Please attach a copy of your declarations page from your current primary insurer.
If you are a Resident or Fellow, include a letter from your program director allowing you to moonlight.

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 MEDICAL PROFESSIONAL LIABILITY COVERAGE. I AGREE TO REPORT ANY CHANGE IN THE DURATION OR NATURE OF MY PRACTICE WHICH MAY AFFECT MY ELIGIBILITY FOR A MOONLIGHTING CREDIT TO THE UNDERWRITING DEPARTMENT OF COVERYS AS SOON AS ANY SUCH CHANGE OCCURS. I AGREE TO ALLOW COVERYS TO VALIDATE THE ABOVE INFORMATION AS IT MAY DEEM NECESSARY.

FURTHER, I UNDERSTAND THAT COVERAGE UNDER ANY POLICY ISSUED BASED ON INFORMATION CONTAINED HEREIN WILL BE RESTRICTED TO ACTIVITIES CONDUCTED OUTSIDE THE SCOPE OF MY PRIMARY PLACE OF CLINICAL PRACTICE.

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 OF 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.

_____ _____
Signature of Applicant Title

_____ _____
Printed Name of Applicant Date

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

_____
Printed Name of Producer