PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

Request for Part-Time Coverage

1. Name: _____ MD ____ DO ____ Other _____

2. Policy No: _____ (Leave blank if you do not have your professional liability insurance with CARE.)

3. Effective Date for Part-Time Coverage: _____

4. Number of hrs. per week for which coverage is requested _____ Patient load per week _____
(Practice hrs. consist of: hospital rounds, call hours involving patient contact, communication with other physicians, patient visits and charting.)

5. If 20 hrs. or less, how long have you practiced part-time: _____

6. Coverage specialty requested: _____

7. Part-time practice description. Please check all that apply:

____Pregnancy, dependent care or personal preference. Please describe in the Remarks Section

____ Semi-retirement. Please provide your date of birth: _____

____ Disability. Type: _____ (Submit written explanation from treating physician)

____ Majority of employment insured through hospital. Please list hospital(s) in the Remarks Section

____Other. Please describe in the Remarks Section (Remarks section must be completed if checked)

Remarks (If need additional space please provide separate pages)

_____

_____

_____

_____

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

9. Submit proof of coverage for any employment listed above which is to be excluded on your CARE policy.

Signature _____ Date _____