COVERAGE APPLICATION ADDENDUM

REQUESTING ADJUSTED RATE FOR PART-TIME PRACTICE

NAME OF INSURED: ______________________________

OFFICE HOURS: Indicate your normal weekly office hours by day of the week:

DAY:	SUN	MON	TUE	WED	THU	FRI	SAT
HOURS:							

HOURS WORKING EACH WEEK:

How many hours per week do you spend interacting with patients, reviewing / documenting patient files, or supervising others who are working with patients or on patient files? [ ]

How many patient appointments do you typically have each week? [ ]

How much time do you typically spend for each patient visit? This includes time spent preparing for the patient visit, meeting with and treating the patient, and completing documentation regarding the patient visit? [ ]

ANNUAL VOLUME: About how many patient visits did you have last year? [ ]

CERTIFICATION: I hereby declare the above statements are true, and I have not misstated or suppressed any facts. I understand the insurance company has the right, but not the duty, to audit my books to confirm the above is true and correct. I represent that the name signed/typed below was signed/typed by the Applicant, and the Applicant agrees to be fully bound by every answer in this Application. I further understand that any fraudulent or intentional misrepresentation could result in my rate being increased, coverage being canceled, and/or a claim being denied.

Signature: ______________________ Date: ______________________

Name: ______________________

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