Curi

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PHYSICIAN PART-TIME QUESTIONNAIRE

Provider Name: _____ **Policy Number:** _____

Date of Birth: _____ **Practice Name:** _____

This supplement is for physicians working under the Direct Primary Care or Concierge Medicine health care delivery model, or working on a part-time or semi-retired basis to determine if a premium discount is available.

1. How many hours do you work per week? *When providing average hours per week, please include all patient visits, consultations, telehealth visits, on-call hours involving patient care, hospital rounds, supervision of other health care workers, charting, recordkeeping, house calls, phone calls, consultation with other providers, administrative duties, etc.*	_____ hours
2. Describe your typical practice work week:	
3. When did you begin working part-time?	
4. On average, how many patients do you see each week?	_____
5. What is your anticipated number of patients for the next year?	_____
6. What is the maximum number of patients you have in your practice?	_____
7. Please list your approximate patient practice volume for the preceding five (5) years? _____Last year _____1st Year _____2nd Year _____3rd Year _____4th Year	
8. Do you perform surgery? If yes, list procedures in the additional comments	❑ Yes ❑ No
9. How many babies on average do you deliver per year?	_____
10. Do you perform invasive, high - risk medical procedures or techniques? If yes, please describe:	❑ Yes ❑ No

11. Do you have medical professional liability coverage in place with another carrier to cover part of your work? ❑ Yes ❑ No

If yes, please provide the employer/facility name, location for which that coverage applies:

_____

Please provide a copy of the Declaration Page or Certificate of Insurance.

How many weekly hours are you looking for coverage? _____hours**

**Please note, we will be limiting your policy to the portion of your work not covered under another medical professional liability policy.*

***Including the duties described in question 1.*

12. Do you practice under the Direct Primary Care health care delivery model? ❑ Yes ❑ No

If yes, when did you begin practicing under this delivery model?

Are all of your patients being seen under this delivery model? ❑ Yes ❑ No

If no, please specify percentages: _____%

13. Do you practice under the Concierge Medicine health care delivery model? ❑ Yes ❑ No

If yes, when did you begin practicing under this delivery model?
Are all of your patients being seen under this delivery model? ❑ Yes ❑ No
If no, please specify percentages:_____%

14. Do you supervise any medical employees? ❑ Yes ❑ No

If yes, please complete the chart below

Provider Name, Designation (MD, CRNA, etc.)	Specialty	Hours Worked	Employment Status*	Hire Date

*Full Time (FT), Part Time (PT), Independent Contractor (IC)

ADDITIONAL COMMENTS

INSURANCE FRAUD WARNINGS

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

TENNESSEE AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. In addition, if an insured or applicant misstates, misrepresents, omits or conceals information, and we rely on such misstatement, misrepresentation, omission or concealment and it is fraudulent or material to our interests or the policy, then we may take action, including denying coverage for a claim or other covered event or rescinding, canceling, or non-renewing the policy or coverage. It is understood that misstatements, misrepresentations, omissions or concealments on the part of the insured are not fraudulent unless made with intent to knowingly defraud.

IN ALL STATES OTHER THAN THOSE LISTED ABOVE: 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 there to, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

NOTICE AND AGREEMENTS

ARIZONA: The Applicant understands all statements and descriptions in any application for an insurance policy or in negotiations therefor, by or in behalf of the corporation, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy unless: Fraudulent; Material either to the acceptance of the risk, or to the hazard assumed by the insurer; The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

IN ALL STATES OTHER THAN THOSE LISTED ABOVE: The Applicant hereby declares that the above statements/responses made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of this application are true and the Applicant agrees that this application, and any Attachments, shall be the basis of the contract with one of the following companies depending on admitted states, MMIC Insurance Inc, UMIA Insurance Inc, Arkansas Mutual Insurance Company Inc. I agree to notify MMIC Insurance Inc, UMIA Insurance Inc, or Arkansas Mutual Insurance Company Inc. if there are any future material changes in any answer to this application, or its Attachments, including without limitation, any change in professional specialty, scope of practice, new contract, new location, affiliation or working arrangement with any other dentist, physician, firm or professional association.

The Applicant understands that any intentional material misrepresentation or intentional omission made by the authorized signature on this application, may act to render any contract of insurance null and without effect. The Applicant understands that if the Applicant fails to comply with these terms, the insured entity may have no coverage for any claim under any policy of insurance for which the Applicant is applying. The Applicant also understands that MMIC Insurance Inc, UMIA Insurance Inc, Arkansas Mutual Insurance Company Inc. may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if issued, after the issuance of a contract of insurance.

Therefore, the Applicant hereby instructs any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to one of the following companies depending on admitted states, MMIC Insurance Inc, UMIA Insurance Inc, Arkansas Mutual Insurance Company Inc. any information regarding the Applicant, which MMIC Insurance Inc, UMIA Insurance Inc, or Arkansas Mutual Insurance Company Inc., in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder. This application is considered part of the policy, if a policy is issued.

As the representative for the Applicant, I represent that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations. I agree that a copy of my signature may be relied upon as if it were the original. My signing of this application does not bind the insurance company to sell nor does it bind the applicant to purchase the insurance.

Authorized Signature: _____ Date: _____

Print Name and Title: _____