



CHANGE IN PRACTICE QUESTIONNAIRE

This questionnaire is to be completed for any change in practice including part-time status, practice locations, medical specialty or surgical procedures.

Provider Name:		Curi Policy Number:	
1. On what date did you begin, or do you plan to change your practice (MM/DD/YYYY)?			
2. Please describe your change in practice.			
3. Do you plan to retire within the next twelve months?			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. If your change in practice modifies your hours per week , please provide the number of hours for each area of your practice:			
Practice Activity		Hours Per Week	
Patient visits and consultations (including consultations with other providers)			
Telehealth visits/phone calls			
On-call hours			
Hospital rounds			
Supervision of other healthcare workers			
Charting/ record keeping / administrative duties			
House calls			
		Total	
5. Specify below any changes to the practice locations where coverage under your current policy is intended to apply . For number of hours, use average hours per week .*			
Practice/Facility Name	Street Address, City & State	Specify Employee, Contractor or Owner	# of Hours*
6. If your change in practice includes practicing in a new state, list state license number here:			
7. If your change in practice includes a change in procedures, specify the surgical category that applies:			
<input type="checkbox"/> No Surgical Procedures	Contemplates no surgical procedures performed.		
<input type="checkbox"/> Minor Surgical Procedures	Contemplates minimally invasive procedures that do not open body cavities or permanently impair a patient's physical or physiological function; procedures are performed on superficial tissue, such as cuts, wounds, or foreign objects, and can be done with minimal equipment and local anesthesia. Procedures can be performed in a doctor's office and patients are conscious during the procedure.		
<input type="checkbox"/> Surgery	Contemplates surgical procedures that involve opening a body cavity, removing an organ or body part or repairing a large body part; may also include procedures that may cause permanent physical or physiological impairment, or procedures that involve extensive tissue dissection.		
8. Do you perform obstetrical procedures? If yes, please complete the Obstetrical Services Underwriting Questionnaire.			<input type="checkbox"/> Yes <input type="checkbox"/> No

I declare the information provided herein is complete and accurate. Providing false or misleading information may result in limiting or voiding coverage. I acknowledge a duty to timely inform you of any changes to answers provided herein.

Signature

Print Name

Date