



- Medical Professional Mutual Insurance Company
- ProSelect Insurance Company
- ProSelect National Insurance Company

Name	Policy Number
------	---------------

Address

Hospitals at which the member has admitting privileges:

Average Direct Patient Care Hours per week _____

Average Total Hours of Work per week _____
(including direct patient care hours and other professional activities such as teaching, research, and administrative activities)

How many years have you been practicing 21 hours or less per week or 80 hours or less per month? _____

Eligibility for the credit will be based upon the number of hours of direct patient care engaged in by the insured. "Direct patient care" is defined as any activity that could form the basis for the assertion of a professional liability claim by a patient against the insured. Direct patient care includes the activities listed below, whether occurring during the course of the insured's office practice, outpatient hospital practice, clinical practice, in-patient hospital practice (including but not limited to attending duties), specialty consultation, on-call time (including any telephone consultation), or any patient follow-up:

- a. examining or testing the patient;
- b. making or consulting in the diagnosis of the patient's medical or dental condition;
- c. performing any medical or dental procedures on the patient;
- d. prescribing any medication or medical or dental treatment for the patient;
- e. dictating, updating, or reviewing medical records;
- f. making rounds on patients;
- g. consulting with or writing to the patient, the patient's relatives or representatives, a referring physician or dentist or a consulting physician or dentist concerning the patient's medical or dental care and treatment;
- h. consulting with, observing or supervising members of the healthcare staff, including residents, nurses, assistants, hygienists and any other healthcare personnel responsible for the patient's medical or dental care, with respect to the patient's medical or dental care and treatment.

It is understood and agreed that the foregoing guidelines do not necessarily include an exhaustive list of direct patient care activities. Accordingly, any activities which the insured has reason to believe could form the legal basis for a professional liability claim, whether or not such activities are specifically set forth in the foregoing guidelines, are included as direct patient care activities.

TERMS AND CONDITIONS

I hereby apply for the Limited Practice Credit from the regular premium for my medical malpractice insurance policy to be issued by ProMutual Group. In making this application, I certify the following:

1. I will **not** spend more than 21 hours per week or 80 hours per month, involved in direct patient care.
2. I will maintain an unrestricted license to practice medicine/dentistry.

(continued on the reverse side)

TERMS AND CONDITIONS (continued)

3. I agree to maintain accurate records recording the number of hours spent by me in direct patient care and to allow the Company to audit those records on-site during reasonable business hours and without prior notice or approval, provided that such an on-site audit does not unnecessarily interfere with the operation of my practice.
4. I agree to report any change in the nature of my practice which may affect my eligibility for a Limited Practice Credit to the Underwriting Department of the Company as soon as any such change occurs.
5. I understand that if I exceed the maximum number of hours in direct patient care or otherwise fail to comply with the requirements for this credit, the Company may revoke the credit and I will be required to refund the amount of the credit for any policy year for which non-compliance is found within thirty (30) days or my policy will be cancelled for non-payment of premium. I further understand that if I lose my credit for non-compliance with the requirements, I will be ineligible for a further credit for a minimum of two (2) policy years following such revocation, and in no event will I be eligible for a further credit unless I satisfy the Company that I have complied with the requirements for the credit.

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 PROFESSIONAL LIABILITY INSURANCE COVERAGE.

Date

Signature of Applicant