GenStar

SUPPLEMENTAL APPLICATION

REQUEST FOR PART-TIME COVERAGE

PHYSICIANS AND SURGEONS
Claims-Made and Reported Coverage

Instructions to the Applicant.

A. Please answer **all** the questions on this supplemental application. The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.

B. If a question is not applicable, state "N/A". If more space is required to answer a question, please continue on your letterhead.

1. The application must be signed and dated by the physician named below.

I. GENERAL INFORMATION

1	Applicant Name:
2	When did you begin to practice part-time?
3	Do you expect a change in your part-time or limited practice in the future? Yes ◯ No ◯ If so, please provide a date: And, details of the change:
4	Please provide the reason for practicing on part-time basis:
5	Please provide the number of hours worked and patient load per week for which coverage is being requested: Number of hours: Number of patients: Practice hours include: actual patient care and record keeping, hospital rounds, consultations with other physicians, administrative duties for your practice, answering and returning patient calls and emergency care)

ADDITIONAL INFORMATION

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

Section # and Question #	**Comments**

Signature:	Date:
Print or Type Name:	