HALLMARK Pro
PROFESSIONAL LIABILITY
20 North Wacker Drive, Suite 770, Chicago, Illinois 60606 MEDMAL@hallmarkgrp.com

Part-time Practice Questionnaire

Physicians & Surgeons Medical Professional Liability Insurance Claims Made & Reported Coverage

Practice Characteristics

Please explain why you are requesting coverage for a part-time exposure:

Please explain why you are requesting coverage for a part-time exposure:

Other Coverage and Experience

Do you carry professional liability coverage for a location, procedure or practice situation that can be excluded from your part-time coverage policy? ☐ Yes ☐ No

If "Yes", please provide the following information regarding any professional liability policy that is currently active and that you plan to maintain through the prospective policy period:

Policy Period	Insurer	Policy Limits	Deductible	Policy Type	Premium	Total# of Claims*
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		

** Total # of claims by carrier regardless of payment, no payment, dismissed or open.*

NOTICE TO THE APPLICANT—PLEASE READ CAREFULLY

This supplemental application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the Company and/or affiliates thereof receives notice is on file with the Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is assigned and the effective date of the policy, the Applicant will promptly notify the Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY:

I warrant to the Company that I understand and accept the notice stated above, and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein.

Must be signed by the proposed locum tenens physician within 60 days of the proposed effective date.

Signature: _____ Date: _____

Name of Applicant: (Please Print) _____ Title: _____

Signing this form does not bind the Applicant or the Company to complete the Insurance.

Notice to Applicants: 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 thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.