

AMERICAN PHYSICIANS ASSURANCE CORPORATION

Home Office: 1301 N. Hagadorn Road • P.O. Box 1471 • East Lansing, MI 48826-1471 • 1-800-748-0465

New Mexico Office: 7770 Jefferson St., NE, Suite 410, Albuquerque, NM 87109 • 1-800-880-9485



Request for Part-Time Coverage

Please type or legibly print your responses in full.

1. Name: _____ 2. MD DO Other: _____
3. APA Policy No.: _____ (Leave blank if you do not currently have your professional liability insurance with APA)
4. I am requesting coverage on a part-time basis effective: _____
5. Number of hours worked per week for which coverage is being requested: _____ 6. Patient load per week: _____
(Practice hours consist of: hospital rounds, on call hours involving patient contact, consultation with other physicians, patient visits and charting)
7. Specialty for which you are applying for coverage: _____
8. My practice is reduced due to:
 _____ Pregnancy or dependent care
 _____ Semi-retirement Date of Birth _____
 _____ Disability: Type: _____ (Submit written explanation from treating physician)
 _____ Majority of time is spent in a teaching capacity - Hours per week: _____ Place: _____
 _____ Majority of employment insured through hospital.
 _____ Majority of employment in another state, which is insured elsewhere. State: _____
 _____ Majority of practice is insured through another carrier, entity or employer
9. How long do you anticipate your coverage will be at these reduced hours: _____

10. Please complete for each activity to be **excluded** on your American Physicians Assurance policy:

HOSPITAL OR OTHER ENTITY PROVIDING COVERAGE	ADDRESS OF EMPLOYER	PROFESSIONAL LIABILITY CARRIER	SPECIALTY PRACTICED THERE	HOURS WORKED PER WEEK
EMPLOYMENT IN ANOTHER STATE				

12. Please submit proof of coverage for any employment listed above which is to be **excluded** on your APA policy.

Signature: _____

Date: _____