Princeton Insurance
a MedPro/Berkshire Hathaway company

Part-Time Application

Name Insured: ____

Agency Name: ______________________ Policy Number: ____________________

Effective date of change: ____

1. List all locations where you work (mail will be sent to the first address unless indicated otherwise).

Street City County State Zip Phone #

(1)____

(2)____

(3)____

(4)____

2. Please indicate total hours per week and month devoted to the following activities at each location:

	Loc. (1)		Loc. (2)		Loc. (3)		Loc. (4)	
	Wk	**Mo**	**Wk**	**Mo**	**Wk**	**Mo**	**Wk**	**Mo**
a. Actual patient care including recordkeeping and hospital rounds								
b. Office hours								
c. Administrative duties								
d. Surgeries and assists								
e. House calls and nursing home visits								
f. Utilization Review								
g. Total Practice Hours								

3. Please provide a detailed description of how your practice has changed:____________________
____
____

4. Please advise the reason your practice has changed from full-time to part-time.____________________
____

5. How long do you anticipate practicing on a part-time basis? ____________________

6. If you are a member of a corporation or partnership, how has your membership status changed?____________________
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Signature of Applicant: ______________________ Date: ______________________

Part-time rate is subject to Company approval.

All questions must be answered for part-time rate to be considered.