

# Request for COVID-19 Related Part-Time Discount

Insured Name: \_\_\_\_\_  
First Middle Initial Last

Policy Number: \_\_\_\_\_

Email: \_\_\_\_\_

Date that your hours and patient visits decreased due to COVID-19 related circumstances: \_\_\_\_\_

If you have already returned to Full-Time practice, please indicate the date: \_\_\_\_\_

During this time, how many patient visits did you average per week? \_\_\_\_\_

During this time, how many hours per week were you treating patients? \_\_\_\_\_

Provide your signature if you are in agreement with the terms below.

- I attest that the answers provided above are true and accurate;
- Receiving a Part-Time Discount on my Professional Liability policy is related to a decrease in patient visits and/or hours due to the COVID-19 pandemic;
- I will notify the insurance company upon my return to seeing patients on a full-time basis;
- I acknowledge that this change is temporary and NCMIC Insurance Company will provide me thirty (30) days notice when the Part-Time Discount is being removed from my policy. At that time, if I am still working part-time hours, I will have to complete an application for the discount to remain.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Return the completed form by email or fax.***



Email:  
submissions@psicinsurance.com



Fax:  
1-800-788-8540