Nevada Mutual Insurance Company

PHYSICIAN / SURGEON SEMI-RETIRED / DISABLED SUPPLEMENTAL APPLICATION

Complete the following application if you conduct a semi-retired practice or are disabled.

Physician Name: ________________________________ Date of Birth: _________________

Agency Name: _________________________________ Policy Number: NV_____________

1) Please describe your typical practice work week in detail using a narrative format:
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2) Indicate which year you began a semi-retired or limited practice: _______________
3) What are the total number of hours devoted per week, to the following aspects of <u>your</u> practice?

<u>PER WEEK</u>

a) Actual patient care _______
b) Actual patient record keeping _______
c) After hours emergency care _______
d) Night telephone calling of your patients for that day _______
e) Hospital Rounds ____________
f) Administrative duties for the office ___________
g) Teaching ____________

4) Indicate type of practice: Solo Partnership Corporation
5) Do you have any associates and / or partners in your practice? Yes No
6) Are you disabled? Yes No
(**<u>If yes</u>**, please explain your disability and submit medical documentation)

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______________________________ ____________________

Signature of Applicant Date

Signing this application supplement does not bind the Company to complete the insurance. All information in this application is considered material and important. If the Company agrees to be bound under the terms of the application, your policy is void if you hide any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.