



- Medical Professional Mutual Insurance Company
- ProSelect Insurance Company
- ProSelect National Insurance Company

Policyholder	Policy Number
--------------	---------------

In order to issue you a moonlighting policy, please complete the following questionnaire for our records. This questionnaire will become part of your malpractice insurance application, and as such, all provisions of your malpractice insurance application will apply to this questionnaire.

Where is your primary place of clinical practice?

How many hours per week do you work at your primary place of clinical practice?

Please complete the following based on your moonlighting activity:

Location	Specialty	# Hours per Week
1:		
2:		
3:		
4:		

Please attach a copy of your Declarations page from your current or previous primary insurer.
If you are a Resident or Fellow, include a letter from your program director allowing you to moonlight.

I hereby certify under the pains and penalties of perjury that the foregoing representations are true and that they are made by me in order to receive a credit on my otherwise applicable premium for medical professional liability coverage. I agree to report any change in the duration or nature of my practice which may affect my eligibility for a moonlighting credit to the Underwriting and Policy Services Department of ProMutual Group as soon as any such change occurs. I agree to allow ProMutual Group to validate the above information as it may deem necessary.

Further, I understand that coverage under any policy issued based on information contained herein will be restricted to activities conducted outside the scope of my primary place of clinical practice.

Date

Signature of Physician

If you have any questions regarding the completion of this questionnaire, please contact the Underwriting Department.