Physicians Insurance
A MUTUAL COMPANY

PRACTICE IMPACT DUE TO COVID-19
PART-TIME CHANGE REQUEST

Physicians Insurance is accommodating temporary part-time changes for up to 90 days for practices impacted by COVID-19.

To request a premium discount as a result of the impact of COVID-19 on your practice, e-mail this completed form to: COVID19@Phyins.com. A separate form is needed for each provider requesting a discount. For large groups (10 or more), please contact us to complete a group roster.

Physician's Name: ____________________

Policyholder Name (if different): ____________________ Policy #: ____________________

Specialty: ____________________

1. Prior to the COVID-19 state of emergency, how many hours did you practice per week? ____________________
   Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, Advance Practice Clinician supervision, telemedicine, and on-call hours involving patient contact (whether direct or by telephone).

2. In which ways is your practice impacted? (Check all that apply)
   - ☐ State mandated cessation of elective procedures
   - ☐ Reduced in person patient care
   - ☐ Need to take time off to care for family member
   - ☐ Reduced hours due to staff reduction
   - ☐ Decreased or eliminated access to surgical facilities
   - ☐ Other: ____________________

3. **Please indicate the total number of hours per week you currently practice or were practicing while impacted by COVID-19:**

   ____

   Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, Advance Practice Clinician supervision, telemedicine, and on-call hours involving patient contact (whether direct or by telephone).

   Requested Effective Date: ____________________

   Return to Pre-COVID-19 hours Date (if less than 90 days from Effective Date): ____________________

By signing this form, you confirm you understand that you are requesting a premium credit due to impact to your practice as a result of COVID-19. All information disclosed on this form is subject to the anti-fraud statement contained on the initial application.

Signature: ____________________

Today's Date: ____________________

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