PRACTICE IMPACT DUE TO COVID-19

ProAssurance
Treated Fairly

Email this completed form to COVID-19@ProAssurance.com to request a premium discount as a result of the impact of COVID-19 to your practice. One form is needed for each individual requesting a discount if in a group practice. All information disclosed on this form is subject to the anti-fraud statement contained on the initial application.

Insured Physician's Name: _____

Specialty: _____

Policyholder Name: _____ Policy Number: _____

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, paramedical 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. How many hours is the practice for which you provide services open per week? _____

4. Please indicate total number of hours per week devoted to the following activities:

Practice Activities	**Hours per Week**
Hours per week spent on direct patient care: (office visits, office procedures, procedures performed at external facilities)	
Hours per week spent supervising paramedicals:	
Hours per week on-call:	
Hours per week spent on remote patient care: (phone consultations, prescription refills, telemedicine visits)	
Hours per week spent on administrative tasks and duties related to your practice (including telephone contact with patients and charting):	
Your house calls and/or nursing home visits:	
Your other patient care-related activities:	
Other: _____	

5. Please state your practice revenue, number of procedures/surgical cases, and patient visits for 2019:

   Practice Revenue: _____

   Number of Procedures/Surgical Cases: _____

   Patient Visits: _____

By signing this form, you confirm your understanding that you are requesting a premium credit due to impact to your practice as a result of COVID19. If approved, you will be moved to Part Time status and receive up to a 50% discount off your premium for no more than a 60 day period, beginning on your requested effective date.

Signature: _____

Requested Effective Date: _____ Today's Date: _____