PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®

Dental Student's Professional Liability Coverage Application

THE INSURANCE YOU ARE APPLYING FOR PROVIDES COVERAGE ON A CLAIMS-MADE AND REPORTED BASIS AND, SUBJECT TO THE PROVISIONS OF THIS POLICY, APPLIES ONLY TO CLAIMS MADE AGAINST AN INSURED AND REPORTED TO THE COMPANY IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF SUCH POLICY. CLAIM EXPENSES REDUCE THE LIMIT OF LIABILITY.

APPLICATION MUST BE RECEIVED IN OUR OFFICE NO LATER THAN TWO WEEKS PRIOR TO PROOF OF INSURANCE REQUIREMENTS

Please complete all information requested and mail check for full premium to B&B Protector Plans, Inc. P.O. Box 173569, Tampa, Florida 33672-1166. For assistance or questions, please call 1-800-922-5694.

Contact Information

Applicant Name: ______________________

Current Address: ______________________

Post-Graduation Address: ______________________

E-mail Address: ______________ Website: ______________

Phone Number: ______________ Fax Number : ______________

Policy Request Information

Name of Dental School: ______________________ Graduation Date: ___/___/___

After Graduation I plan to: ☐ Further my education ☐ Join an existing practice ☐ Open my own practice ☐ Other: __________

Are you a Post Graduate? ☐Yes ☐ No

Does your dental school provide Professional Liability Coverage for you? ☐Yes ☐ No

Have you ever had an application for insurance declined, refused, cancelled, or non-renewed?
(NOT APPLICABLE IN MISSOURI) ☐Yes ☐ No

If yes, please explain: ______________________

I will take the following: ☐ CRDTS ☐ NERB ☐ SRTA ☐ WREB ☐ Externship ☐ Others: __________

Exam Dates: ______________________ (Proof of professional liability coverage is required for board examinations)

Desired Effective Date: ___/___/___

Upon approval of your application, coverage will become effective on the date requested or the date we receive your application, whichever is later. Premium for this coverage is $25.00. Please make your check payable to B&B Protector Plans, Inc. and mail it with this application to the address above.

AUTHORIZATION

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I agree that any coverage issued will be contingent upon the truth of the preceding information. I further understand that any incorrect or incomplete statement could invalidate my coverage. I hereby authorize AAIC to release the information on this application and associated underwriting information.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, KANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, PUERTO RICO, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

Signature of Applicant ______________________ Date ______________________

If you apply your signature to this application electronically, you hereby consent and agree that your use of a key pad, mouse or other device to affect your electronic signature constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

Master Policy No. ______________________ Certificate No. ______________________