PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®

Locum Tenens Application

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant in ink.
3. Applications must be signed and dated by the Insured and the Locum Tenens.

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued. Additional information may be required upon review of the application.

I agree that any coverage issued will be contingent upon the truth of the following information:

LOCUM TENENS COVERAGE IS SUBJECT TO PRIOR APPROVAL BY AAIC.

THE FOLLOWING SECTION MUST BE COMPLETED BY THE INSURED

Policy Number:____________________________________

Full Name:____ ☐ DDS ☐ DMD ☐ MD ☐ BDS ☐ MS

Address:____

City / County / State / Zip:____

E-mail Address:____

Reason for Locum Tenens Coverage:____

____

THE FOLLOWING SECTION MUST BE COMPLETED BY THE LOCUM TENENS

Full Name:____ ☐ DDS ☐ DMD ☐ MD ☐ BDS ☐ MS

Home Address:____

City / County / State / Zip:____

E-mail Address and Phone Number:____

License Number:________________________________ Specialty:________________________________

Have any Professional Liability claims been filed against you during the past ten years?.. ☐ Yes ☐ No

If **"Yes"**, please explain:____

____

____

Has any insurer canceled or declined your Professional Liability coverage during the past ten years?... ☐ Yes ☐ No

(THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS)

If **"Yes"**, please explain:____

____

____

Number of days coverage is requested:____________ From ____________ to ____________

Subject to approval by Underwriting, coverage, if any, provided will be via an endorsement added to the Insured's policy. The endorsement will include coverage for the approved locum tenens but only with respect to professional services performed on the Insured's behalf and subject to all terms and conditions of coverage. The limit of liability on the Insured's policy will not apply separately to the locum tenens; rather the limit of liability will apply on a shared limit basis. The coverage shall apply to claims arising out of dental incidents which happen during the period of time period requested 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 in full Date

____ ______________

Signature of Locum Tenens Date

____

Agent's Signature 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.

PRE-FILL AGENCY INFORMATION

RETURN TO:

State Administrator Name:______________________________________

Address:______________________________________

City:____________________ State:__________ Zip Code:__________

Phone #: ____________________ Agent's License Number: ____________________

The Professional Protector Plan is a registered trademark of B & B Protector Plans, Inc.. Coverage is underwritten by AAIC.