PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®

Part-Time Supplement

DEPENDING ON THE COVERAGE YOU ELECT, THE POLICY YOU ARE APPLYING FOR MAY PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR DURING AN APPLICABLE EXTENDED REPORTING PERIOD.

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.

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:

Named Insured:_____ **Policy Number:**_____

Expiration Date:_____

Please complete the following to determine part-time discount eligibility. (part-time eligibility = Total of 20 hours or Less Per Week.)

1. Provide the total number of hours **Per Week** you devote to the following aspects of your practice:

_____ Actual patient care	_____ After hours emergency care
_____ Actual patient record keeping	_____ Hospital hours
_____ Administrative duties for your practice	_____ Returning patients' calls (including after hours)

2. Please list your exact office hours (example: Monday 9-12):_____

3. When did you first begin to practice part-time?_____

4. Please state the reason you are practicing on a part-time basis:_____

5. Do you expect this situation to change in the future?_____

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 _____

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.

AGENCY INFORMATION

RETURN TO:

State Administrator Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Agent's License Number: _____

Send E-mail