PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®

Professional & General Liability Insurance for Dentists

Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A. 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.

Requested Effective Date:_______/_______/_______ ☐ **New Policy** ☐ **Rewrite of Policy Number:**______________________________

PLEASE TELL US ABOUT YOURSELF

1. **Full Name:**______________________________ ☐ DDS ☐ DMD ☐ MD ☐ BDS ☐ MS
2. **Mailing Address**:______________________________
   City / State / Zip:______________________________
3. **E-mail Address**:______________________________ 4. **Website:**______________________________
5. **Would you would like the PPP's quarterly Risk Management Newsletter sent via email**? ☐ Yes ☐ No
6. **Telephone Number:** ______________________________ 7. **Fax Number:** ______________________________
8. **All Dental Schools Attended:**______________________________ 9. **Month / Year of Graduation:**______________
10. **Did you complete a residency?**.. ☐ Yes ☐ No
    If "<u>Yes</u>", Specialty:______________________________ Month / Year of Completion:______________
11. **Are you entering practice for the first time**?.. ☐ Yes ☐ No
12. **Have you ever practiced dentistry outside of the United States and / or its territories?**.. ☐ Yes ☐ No
    If **"Yes",** please explain: ______________________________
13. **Date of Birth**:______________________________ 14. **Years in Practice**:______________________________
15. **How many hours per week do you practice (include administrative duties, record keeping, lab work, patient visitation and consultation)?**______________**
    **If 20 hours or less, please complete a Part-time Supplement provided by your agent.
16. **Under which business structure do you practice?**
    ☐ Sole Proprietor ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Incorporated ☐ Partnership
    ☐ Employee Dentist ☐ Independent Contractor ☐ Faculty (**Occurrence** coverage only) ☐ Volunteer (**Occurrence** coverage only)

    If applicable, please list name of Employer / Facility: ______________________________

    If you volunteer, please describe volunteer services provided: ______________________________

    If you volunteer, will you receive remuneration for your volunteer services? ☐ Yes ☐ No
17. **Practice addresses and percentage of practice at each address** (**total of percentages must equal 100%**):

    A. Primary:______________________________
    Street | City | County | State | Zip Code | %

    B. ______________________________
    Street | City | County | State | Zip Code | %

    C. ______________________________
    Street | City | County | State | Zip Code | %
18. **Indicate your Practice Specialty (please check all that apply):**
    ☐ General Dentistry ☐ Dental Radiologist ☐ Periodontics ☐ Oral / Maxillofacial Surgery ☐ Dental Anesthesiologist
    ☐ Endodontics ☐ Oral Radiology ☐ Prosthodontics ☐ Pediatric Dentistry ☐ Full-time Faculty-Non-Intramural

☐ Orthodontics ☐ Public Health ☐ Oral Pathology ☐ Other - describe:____

PLEASE TELL US ABOUT YOUR PROFESSIONAL LIABILITY COVERAGE NEEDS

19. Select the Professional Liability coverage type and limits desired. All limits may not be available in all states (select either Claims-Made or Occurrence):
PLEASE CONTACT YOUR AGENT IF HAVE ANY QUESTIONS REGARDING THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE AS WELL AS FOR DETAILED INFORMATION REGARDING AN EXTENDED REPORTING PERIOD AS IT RELATES TO CLAIMS-MADE COVERAGE.

☐ **Claims-Made Coverage****

☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $3,000,000 ☐ $2,000,000 / $4,000,000 ☐ $2,000,000 / $6,000,000 ☐ $3,000,000 / $3,000,000
☐ $3,000,000 / $6,000,000 ☐ $4,000,000 / $4,000,000 ☐ $5,000,000 / $5,000,000 ☐ $5,000,000 / $6,000,000 ☐ $5,000,000 / $8,000,000
☐ Other ________________________________
(STATE EXCEPTIONS MAY APPLY)

**THIS IS AN APPLICATION FOR CLAIMS-MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

☐ **Occurrence Coverage**

☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $2,000,000 ☐ $2,000,000 / $6,000,000 ☐ Other ____
(STATE EXCEPTIONS MAY APPLY)

20. If Claims-Made Coverage is desired, please complete the following:

A. Are you applying for prior acts coverage from AAIC? .... ☐ Yes ☐ No

B. Retroactive Date / Prior Acts Date on your current Claims-Made policy**: _____/_______/________

****If prior acts is desired, please attach a copy of your last declaration page (face sheet)

C. Was an Extended Reporting Endorsement (tail) purchased from your previous carrier? .... ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR GENERAL LIABILITY NEEDS

21. Do you desire shared or separate limits of liability to apply to each location (limits will be equal to your professional liability limits):

☐ Shared (Limits are Shared with each location at no additional cost) ☐ Separate (each location has its own set of limits and an additional charge applies)

22. Have you had any general liability losses in the past 3 years? (If **"Yes",** please provide a summary of the loss and claim amount) ☐ Yes ☐ No

____

23. Do you desire to increase your limit of liability for ERISA Fiduciary Liability Coverage / Employee Benefits Liability above the included $25,000? ☐Yes ☐No

Coverage is recommended if you sponsor an Employee Benefit Plan. This is NOT the bond for your pension plan. Coverage is written on a Claims-Made basis.

If **"Yes",** check the desired limit of liability: ☐ $100,000 ☐ $250,000 ☐ $500,000 ☐ $750,000 ☐ $1,000,000

24. If you are a TENANT, would you like to increase the standard $500,000 Fire / Water Legal Liability Limit? .... ☐ Yes ☐ No

If **"Yes",** check the desired limit of liability: ☐ $750,000 ☐ $1,000,000

25. If you have an equipment lease, building lease, rental agreement, etc. that requires you to name an entity as an additional insured for general liability purposes, please provide the name and address of the entity as it appears in your contract/agreement:

____

PLEASE TELL US ABOUT YOUR OTHER LIABILITY NEEDS

26. Standard Employment Practices Liability Defense Coverage Only; limits: $25,000 Each Claim, $25,000 Annual Aggregate (coverage is automatically provided unless a STATE EXCEPTION APPLIES).

Do you wish to amend the standard coverage type from Defense Only to Indemnity and Defense (an additional charge will apply)? ☐ Yes ☐ No
If "Yes", please complete the **Employment Practices Liability Indemnity Supplemental Application** provided by your agent.

27. Standard Cyber Liability Coverage: Please select one of the limit options below and answer the following questions:

	Option 1	**Option 2**	**Option 3**
PRIVACY & NETWORK SECURITY AGGREGATE LIMIT	**$250,000**	**$500,000**	**$1,000,000**
COVERAGE PARTS WITH SUB-LIMITS:			
LIABILITY AND RESTORATION COVERAGE	$250,000	$500,000	$1,000,000
INCIDENT RESPONSE EXPENSE COVERAGE	$250,000	$500,000	$1,000,000
PAYMENT CARD COVERAGE	$125,000	$250,000	$500,000
BUSINESS INCOME LOSS COVERAGE	$100,000	$100,000	$100,000
SELECT AN OPTION:	☐	☐	☐

A. **Is your patient information data encrypted AND do you encrypt sensitive patient data when transmitting it outside of your practice?** ☐ Yes ☐ No

B. **Are firewalls in place between your network and the public internet?** ☐ Yes ☐ No

C. **Do you deploy anti-virus, spam and malware defenses on all network workstations?** ☐ Yes ☐ No

D. **Have you ever experienced an extortion attempt of demand with respect to your computer systems?** ☐ Yes ☐ No

E. **Are you or any other proposed insured aware of any actual or alleged fact, circumstance, issue, situation, error or omission or even which:**

Might give rise to an obligation to comply with a law requiring notification of an actual or suspected disclosure of personal information? ☐ Yes ☐ No

Might give rise to a claim against any proposed insured for disclosure, loss or misuse of personal information, invasion or interference with rights of privacy, or which might otherwise result in a claim against any proposed insured with respects to the insurance sought? ☐ Yes ☐ No

If **"Yes"**, please provide details: ____

PLEASE TELL US ABOUT THE PROCEDURES PERFORMED IN YOUR PRACTICE

28. **Which of the following procedures are performed by you?**

☐ Sleep Apnea Therapy or ☐ Fabrication of Snore Guards Only

If Sleep Apnea Therapy is more than snore guards, please indicate the following:

I treat only after referral from physician ☐ Yes ☐ No

I treat without physician referral ☐ Yes ☐ No If **"Yes"**, please provide a written explanation.

☐ **IRREVERSIBLE** TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)

Procedure	Informed Consent Type	Training
☐ Implant Placement/Uncovering/Surgery	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Partially Impacted Third Molar Extractions	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Fully Impacted Third Molar Extractions	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Molar Endodontics on Permanent Teeth	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Mini-Implants	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Conscious Sedation	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ **None of these**		

A. **Have you discontinued any procedures listed above in the last five years?** ☐ Yes ☐ No

Which procedures? ____

29. **Do you or someone under your supervision/direction perform elective cosmetic dermal procedures (including but not limited to Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.)?** ______________________ ☐ Yes ☐ No

If **"Yes"**, please provide an explanation on a separate sheet of paper.

30. **Are you treating patients who are under general anesthesia / deep sedation** (A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposely to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof)? ☐ Yes ☐ No

If **"Yes",** where is the treatment provided? ☐ Your office ☐ Hospital or licensed / regulated surgical center

If administered in **your office**, who administers the anesthesia? ☐ Yourself ☐ Another Dentist, Anesthesiologist, or CRNA **

** Please provide proof of current Professional Liability coverage

PLEASE TELL US ABOUT YOUR PARTICIPATION

31. **Are you a member of your state dental association or society**? .... ☐ Yes ☐ No

If **"Yes"**, provide name of association / society:____

32. **Have you taken one of the following risk management seminars in the last 3 years**? .... ☐ Yes ☐ No

If **"Yes"**, please indicate which one and provide evidence of attendance:

☐ PPP (Evidence not required if you are a PPP insured) Date of Attendance:________/________/________

☐ AAOMS / OMSNIC ☐ AAO ☐ NYSDA / DSSNY ☐ Henry Spenadel ☐ CNA

PLEASE TELL US ABOUT YOUR LICENSE HISTORY

33. **List all states where you hold, or have held, a Dental License even if the license is not currently active (attach a separate sheet if needed):**

State	License Number	Status of License (e.g., active, inactive, pending, etc.)

34. A. **Has any professional conduct or fee complaint ever been filed against you with any licensing or regulatory authority? (State licensing board; DEA; OSHA; EEOC; peer review committee; etc.**) .... ☐ Yes ☐ No

If "**Yes**", provide a copy of the board transcript or other documentation, including resolution and dates.

B. **Have you, your legal entity, or any of your employees ever had any allegations, convictions, or related fines for Medicaid Fraud?** ☐ Yes ☐ No

C. **Has any governmental agency, including a state licensing board, investigated you or taken action against either your dental and/or narcotics license, including suspension, revocation, probation, restriction, denial, or other sanction**? .... ☐ Yes ☐ No

If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.

D. **Have you been charged with or convicted of any criminal charges** (including a DUI, OWI, etc., not including minor traffic violations)? ☐ Yes ☐ No

If **"Yes",** please provide details from investigating agency.

E. **Have you ever had hospital or ambulatory surgical facility privileges involuntarily revoked, suspended or otherwise terminated?** ☐ Yes ☐ No

If **"Yes**", please provide details on additional sheet of paper.

F. **Have you ever been or are you currently being treated for (**if **"Yes**" to any, please provide a physician's statement**)**:

Alcoholism.......... ☐ Yes ☐ No
Drug Addiction.......... ☐ Yes ☐ No
Mental Illness.......... ☐ Yes ☐ No
Physical Impairment.......... ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR PROFESSIONAL LIABILITY CLAIMS HISTORY

35. A. **Has any claim or suit for alleged malpractice ever been brought against you**? .... ☐ Yes ☐ No

If **"Yes"**, please complete a Claim Supplement.

B. **Are you currently aware of any situation that could lead to a malpractice suit against you**? .... ☐ Yes ☐ No

If **"Yes"**, have you reported the situation to your current insurer? .... ☐ Yes ☐ No

If **"Yes"**, please complete a Claim Supplement.

PLEASE TELL US ABOUT YOUR DENTAL LABORATORY / DENTAL IMAGING SERVICES

36. **Do you operate a dental laboratory**? .... ☐ Yes ☐ No

If "**Yes**", do you accept referrals of patients from other dentists? .... ☐ Yes ☐ No

If "**Yes**", is there a separate business entity / corporation for this purpose? .... ☐ Yes ☐ No

37. **Do you provide radiology services to patients of other dentists**? .... ☐ Yes ☐ No

If "**Yes**", is there a separate business entity / corporation for this purpose? ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR PRACTICE

38. A. **Name of your legal entity** (if any):______________________________

Please list any associated "dba" or fictitious entity name: ______________________________

B. **Is the sole function / purpose of this entity for the practice of dentistry**? .... ☐ Yes ☐ No

If **"No"**, please provide details (attach a separate sheet if necessary):______________________________

____

C. **If you have a legal entity**, **do you desire shared or separate limits of liability to apply to your legal entity**?

☐ Shared (limits are shared with you at no cost) ***Shared limits not allowed in CT*
☐ Separate (entity has its own set of limits and an additional charge applies) ***Separate limits not allowed in IN*

D. **Excluding yourself, name all officers or partners of your legal entity ****:______________________________

____

39. If you own your own practice, please provide the number of the following who work for or with you (If none, please write "none" or "0"):

a. **Employee dentists** (other than yourself and/or partners/corporate officers) ** ____________

b. **Independent contractor dentists** ** ____________

c. **All other employees** (hygienists, assistants, technicians, clerical, etc.) ____________

**** NOTE: For all employee dentists, independent contractor dentists, and/or other officers or partners of your legal entity, a separate application OR proof of current Professional Liability coverage must be attached for each.**

40. Not including practice partners, employees and independent contracted dentists as indicated above, are you in a space-sharing arrangement or agreement with another Dentist, Oral Surgeon, or other Healthcare Provider? ☐ Yes ☐ No

If **"Yes"**, please provide the following:

A. Name(s) and specialty of those with whom you are space-sharing:

Name	Specialty
____________	____________
____________	____________

B. Please attach proof of **current** Professional Liability insurance for each individual listed in section A. above.

C. Are patient charts for all space-sharing individuals kept in or retrieved from the same area? ☐ Yes ☐ No

41. Do you now, OR have you within the past 5 years, provided professional services in a setting other than your office? (i.e., spa; residence; school; jail; prison; correctional facility; detention center; halfway house or similar type of facility for adults and/or juveniles; etc.)..... ☐ Yes ☐ No

If **"Yes"**, provide a summary of activities and total number of hours per month: ____________

____

____

42. Does your practice include mobile dentistry? ☐ Yes ☐ No

If **"Yes"**, please answer the following questions:

A. Do you have a separate business entity / corporation set up for this purpose? ☐ Yes ☐ No

If **"Yes"**, business entity / corporation name: ____________

B. Will dentists other than yourself be providing professional services on behalf of the mobile dentistry service? ☐ Yes ☐ No

If **"Yes"**, number of dentists: ____________

C. What type of patients will you be seeing (e.g., nursing home patients, ACLF patients, school children etc.)? ____________

____

D. If further treatment is required, is a protocol in place to instruct the patient, or Guardian thereof, to seek follow up care? ☐ Yes ☐ No

E. Please provide additional comments to help us better understand your mobile dentistry practice: ____________

____

43. Do you practice Holistic dental services? ☐ Yes ☐ No

What percentage of your practice is Holistic? ________ If **"Yes"**, please explain: ____________

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

44. List prior insurance carrier(s) for the past three (3) years. If none, state "None."

Name of Insurance Carrier	Effective Date	Expiration Date	Coverage Type	Limits of Liability
			☐ Claims-made ☐ Occurrence	
			☐ Claims-made ☐ Occurrence	
			☐ Claims-made ☐ Occurrence	

Please explain any gaps in your insurance history: ____________

____

45. Will you be providing dental services for which coverage is provided by another Professional Liability policy? ☐ Yes ☐ No

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

____

46. Are you now practicing, or have you ever practiced, without Professional Liability insurance? ☐ Yes ☐ No

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

____

47. Have you ever had any Professional Liability insurance refused, canceled, or non-renewed? ☐ Yes ☐ No
THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS

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

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. **NOTICE TO COLORADO APPLICANTS:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES. **NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **NOTICE TO NOTICE TO KANSAS APPLICANTS:** an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto. **NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **NOTICE TO LOUISIANA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NOTICE TO MAINE AND WASHINGTON APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NOTICE TO MINNESOTA APPLICANTS:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NOTICE TO NEW MEXICO APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **NOTICE TO NEW YORK APPLICANTS:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information

concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and is subject to a civil penalty not to exceed $5,000.00 and the stated value of the claim for each such violation. **NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **NOTICE TO OKLAHOMA APPLICANTS:** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **NOTICE TO OREGON APPLICANTS:** Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law. **NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly, and with 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 such person to criminal and civil penalties. **NOTICE TO PUERTO RICO APPLICANTS:** The Entity understands that according to the Insurance Code of Puerto Rico (Article 27.320): “Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, it will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with a pain of no smaller fine of five thousand ($5,000) dollars, nor greater of ten thousand ($10,000) dollars or imprisonment by a fixed term of three (3) years, or, both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2). **NOTICE TO TENNESSEE AND VIRGINIA APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **NOTICE TO VERMONT APPLICANTS:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

REMINDER TO INCLUDE:

- ☐ **If no up to date website has been provided, please provide a copy of letterhead or business card (N/A if you are an Independent Contractor or Employee Dentist)**
- ☐ **Part time supplement – if requesting part time credit**
- ☐ **Employment Practices Liability Indemnity (EPLI) Supplemental Application – if requesting EPLI coverage** *(Defense only coverage is automatically included at a $25,000 sublimit)*
- ☐ **Evidence of Risk Management attendance – if requesting RM credit**
- ☐ **“Yes” responses to certain questions require attachment of additional documents/information; is this attached?**
- ☐ **Copy of prior carrier declarations page (if applicable)**
- ☐ **Claim Supplement (if applicable)**

ADDITIONAL INFORMATION MAY BE REQUESTED AND COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

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.

NOTICE TO MARYLAND APPLICANTS: IN THE EVENT OF ANY MATERIAL CHANGE, THE INSURER HAS THE ABILITY TO CANCEL A BINDER OR POLICY, OR RECALCULATE THE PREMIUM FROM THE EFFECTIVE DATE OF THE POLICY, DURING THE FOURTY FIVE (45) DAY UNDERWRITING PERIOD, IN ACCORDANCE WITH MARYLAND INSURANCE ARTICLE §12-106.

PRE-FILL AGENCY INFORMATION

RETURN TO:

State Administrator Name:______________________

Address:______________________

City:______________________ State:____________ Zip Code:____________

Phone #: ______________________ Agent’s Licence Number:______________________

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