ASPEN AMERICAN INSURANCE COMPANY

BROKERING AGENT'S REGISTER No. _____
[Florida Applicant's Only]

PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®

Employment Practices Liability Indemnity Application – Florida

ASPEN AMERICAN INSURANCE COMPANY
(A stock insurance company)
Administrative Offices: 590 Madison Avenue, 7th Floor, New York, NY 10022

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. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED, BY CLAIM EXPENSES, AND CLAIMS EXPENSES WILL BE APPLIED AGAINST THE DEDUCTIBLE, UNLESS OTHERWISE PROVIDED BY THE POLICY. IN NO EVENT WILL THE INSURER BE LIABLE FOR CLAIMS EXPENSE OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY.

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:

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

Requested Effective Date:_____/_____/_____

1. Are you applying for prior acts coverage through AAIC:
   - A. For yourself?..... ☐ Yes ☐ No
   - B. For your legal entity?..... ☐ Yes ☐ No
   - If **"Yes"**, please provide a copy of the declarations page of your current carrier.
   - If **"No"**, was an extended reporting endorsement (tail) purchased from your previous carrier?..... ☐ Yes ☐ No
2. Have you ever had Employment Practices Liability coverage declined, canceled, or non-renewed?..... ☐ Yes ☐ No

   If **"Yes"**, provide reasons:_____
3. Regardless of whether or not such may have been covered by any insurance policy, have you had or do you presently have any employment related claims including, but not limited to, complaints, charges, grievances, arbitrations, litigations, administration, sexual harassment, wage and hour violations, and unfair labor practices?..... ☐ Yes ☐ No

   If **"Yes"**, please explain:_____
4. Are you aware of any facts, incidents, or circumstances which may result in employment-related claims being made against you?..... ☐ Yes ☐ No

   If **"Yes"**, please explain:_____
5. Have you been involved in any administrative proceedings related to EEOC investigations?..... ☐ Yes ☐ No

   If **"Yes"**, please explain:_____
6. Please provide the following information on your employees. Please include any leased employees.

A. Number of non-dentist employees (i.e., hygienist, dental assistant, etc.): _____

B. Number of independent contractor dentists: _____

C. Number of employee dentists: _____

D. Number of independent contractor hygienists: _____

7. Do you have written policies in place relating to professional conduct in the work environment?..... ☐ Yes ☐ No

If **"No"**, provide reasons:_____

_____

8. What are the total revenues for all office locations?_____

DESIRED COVERAGE

9. Limits of Liability (State Exceptions may apply):

☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

☐ $250,000 ☐ $500,000 ☐ $750,000 ☐ $1,000,000 ☐ Other: $_____

10. Limit Type:

☐ All-share – insured dentists will all share the limit of liability selected above as set forth in your Policy

☐ Separate – each insured dentist will have their own separate limit of liability equal to the limit selected above as set forth in your Policy

If **"Separate"**, do you desire shared or separate limits of liability of coverage for your legal entity? ☐ Shared ☐ Separate (additional charges will apply)

Number of partners / corporate officers:_____

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

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____

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.

This application is in compliance with Section 626.752, Florida Statutes. A copy has been furnished to the applicant or insured and coverage is:
[ ] Bound Effective (time) (date); [ ] Not Bound.

BROKER'S SIGNATURE:
Florida requires that we have the Name and Address of your (Applicant's) Authorized Agent or Broker.

Signature of Authorized Agent or Broker: _____

Name of Authorized Agent Broker: _____

Address:_____

License Identification Number: _____