



The Professional Protector Plan® Board Exam Coverage Supplement Claims-Made Professional Liability Coverage - 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.

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:

1.	Date you would like your coverage to become effective *: _____ / _____ / _____ * This will be your Claims-Made Prior Acts Date							
2.	Your Name: _____							
3.	Mailing Address (where we can reach you within the next 90 days): _____ City / State / Zip: _____							
4.	Permanent Address (if different from above): _____							
5.	E-mail Address: _____							
6.	Telephone Number: Daytime: (_____) _____ Evening: (_____) _____							
7.	Date of Birth: _____ / _____ / _____							
8.	Dental school attended: _____ Month / Year of Graduation: _____							
9.	How did you hear about us? <input type="checkbox"/> Social Media <input type="checkbox"/> PPP Website <input type="checkbox"/> Dental School <input type="checkbox"/> Agent: _____ <input type="checkbox"/> Other: _____							
10.	I will take the following examinations: Examination Dates: <table border="1" style="display: inline-table; border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>							
11.	Site Name and Address: _____ City / State / Zip: _____							
12.	Examination completion: I plan to <input type="checkbox"/> Further my education <input type="checkbox"/> Join an existing practice <input type="checkbox"/> Open my own practice <input type="checkbox"/> Other: _____							

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: _____

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