ASPEN AMERICAN INSURANCE COMPANY

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

PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®
Locum Tenens Application – Florida

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

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

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: _____