ASPEN AMERICAN INSURANCE COMPANY

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

The Professional Protector Plan®

Part-Time Supplement - Florida

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

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

__________ Actual patient record keeping

__________ Administrative duties for your practice

__________ After hours emergency care

__________ Hospital hours

__________ 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?______________________________

____

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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.