PROFESSIONAL PROTECTOR PLAN
FOR DENTAL STUDENTS

3101 W. MLK Boulevard • 4th Floor
PO Box 15875 • Tampa, FL 33684-5875

Fax 813.222.4233
Toll Free 800.282.0593
www.protectorplan.com

DENTAL STUDENT'S PROFESSIONAL LIABILITY COVERAGE APPLICATION

APPLICATION MUST BE RECEIVED IN OUR OFFICE NO LATER THAN TWO WEEKS PRIOR TO PROOF OF INSURANCE REQUIREMENTS

Please complete all information requested and mail check for full premium to B&B Protector Plans, Inc. P.O. Box 15875, Tampa, Florida 33684-5875 1-800-282-0593

Contact Information

Applicant Name: ______________________

Current Address: ______________________

Post-Graduation Address: ______________________

E-mail Address: ______________ Website: ______________

Phone Number: ______________ Fax Number : ______________

Policy Request Information

Name of Dental School: ______________ Graduation Date: ___/___/___

After Graduation I plan to: ☐ Further my education ☐ Join an existing practice ☐ Open my own practice ☐ Other: ______________

Are you a Post Graduate? ☐ Yes ☐ No

Does your dental school provide Professional Liability Coverage for you? ☐ Yes ☐ No

Have you ever had an application for insurance declined, refused, cancelled, or non-renewed? ☐ Yes ☐ No

If yes, please explain: ______________________

I will take the following: ☐ CRDTS ☐ NERB ☐ SRTA ☐ WREB ☐ Externship ☐ Others: ______________

Exam Dates: ______________ (Proof of professional liability coverage is required for board examinations)

Desired Effective Date: ___/___/___

Upon approval of your application, coverage will become effective on the date requested or the date we receive your application, whichever is later. Premium for this coverage is $ 30.00. Please make your check payable to B&B Protector Plans, Inc. and mail it with this application to the address above.

I hereby certify that I have read the above questions and that all statements are true, material and complete. I further understand that any incomplete or incorrect statement could void my protection.

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Tennessee and Washington Residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont Residents only: which may be a crime and may be subject to civil fines and criminal penalties.)

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Signature of Applicant Date

Master Policy No. ______________ Certificate No. ______________