



**Board Examination Coverage Supplement
Claims Made Professional Liability Coverage**

Complete all information as requested.

Limits **\$1,000,000 per claim/\$3,000,000 aggregate**

Date you want your coverage to become effective

____ / ____ / ____
Month Day Year

*This will be your claims made Prior Acts date.

Your Name

First Middle Initial Last

Mailing Address

(Where we can reach you within the next 90 days)

Street

City State Zip Code

Permanent Address

(if different than above)

Street

City State Zip Code

E-mail Address

Phone Number

(____) _____ (____) _____
(Area Code) Day (Area Code) Evening

Date of Birth

____ / ____ / ____
Month Day Year

Education

Dental School Attended Month/Year of Graduation

Examination

I will take the following examinations:

Dates

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| | | | | | | | |
|--|--|--|--|--|--|--|--|

Site

Name Street Address City State Zip

Additional Information

Does your dental school provide Professional Liability Coverage for you? Yes No
Have you ever had an application for similar insurance declined, refused, canceled, or non-renewed? **(THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS)**

Yes No

If **Yes**, please explain:

Examination Completion

I plan to -

Further my education Join an existing practice Open my own practice
 Other _____

I hereby request that my application for insurance coverage under the provisions of the Professional Protector Plan® be submitted for consideration to the CNA Insurance Companies. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to the CNA Insurance Companies any and all information requested which may relate to my insurability under the Professional Protector Plan.

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection.

I hereby authorize CNA to release the information on this application and associated underwriting information.

I understand that my Professional Liability Coverage will be written on a "Claims Made form" and acknowledge that this coverage will only respond to claims which result from my candidacy for certification and/or licensure as a dentist.

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.)

to

Signature in full: _____ Date: _____

| RETURN TO: | | |
|-------------------------------|--------|-----------|
| State Administrator Name: | | |
| _____ | | |
| _____ | | |
| Address: | | |
| _____ | | |
| City: | State: | Zip Code: |
| _____ | | |
| Phone #: (_____) _____ | | |
| Agent's License Number: _____ | | |

The Professional Protector Plan® is a registered trademark of B & B Protector Plan, Inc.®. Coverage is underwritten by Continental Casualty Company, one of the CNA property/casualty insurance companies. CNA is a registered service mark and trade name of CNA Financial Corporation.