MLMIC INSURANCE COMPANY

APPLICATION: DENTIST PART-TIME INSURANCE

To:

A premium discount will be provided to qualified dentists whose total practice to be covered under a MLMIC policy will not exceed twenty (20) hours in any given week.

I. Date of Birth: Month ____________ Day __________ Year ______________

II. How many hours weekly do you spend in your total dental practice? (Include all professional activity as a dentist, even if covered by other insurance).

Hours By Day of Week

	In Office	Other	Total Hours
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

(a.) Of these, how many hours are (will be) covered by insurance other than that provided (to be provided) by MLMIC? ________________ Hours per week (if none, list none).

Describe all activities covered by such insurance and name the insurance company (companies):

____

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(Note: As a condition for a reduced rate of premium an endorsement will be attached to your policy excluding coverage for these activities.)

(b.) State the number of hours and describe all activities for which you require coverage under a MLMIC policy. ____________ Hours per week

Activities: ____

____

As a further condition for a reduced premium, I herein consent to an audit of my records to substantiate the limited hours of practice to be covered by MLMIC insurance.

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Signature

NEW YORK STATE INSURANCE DEPARTMENT REGULATION 95 DECLARES THAT:
"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 INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, 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.

__________________ ______________________________________
Date Signature