1800 Northern Boulevard, P.O. Box 9007, Roslyn, NY 11576

(516) 365-2855
Fax: (516) 869-6421
Toll Free: (888) 526-4006

Please make sure all of the information below is accurate in order to prevent any discrepancies, ensuring that you will be covered in the event of a claim.

Name: _____

Policy #: _____

Fax/E-Mail: _____

Date: _____

Please complete the following questions in order to receive the part-time discount.

1. How many hours per week are you practicing? _____

2. Do you employ any dentists? ____Yes ____No If yes, how many? _____

   Name of each employed dentist: _____
   (Please print)

   _____

3. Do you employ any independent contractors? ____Yes ____No If yes, how many? _____

   Name of each employed independent contractor: _____
   (Please print)

   _____

4. How many offices do you own? _____

5. Please provide entity names, if applicable: _____

<u>Please provide a breakdown of daily hours at each location:</u>

Monday:_____ **Tuesday:**_____ **Wednesday:**_____ **Thursday:**_____
Friday:_____ **Saturday:**_____ **Sunday:** _____

Please be advised that if you, any other person or entity insured under your policy, or any agent of yours providing information on your behalf conceals or misrepresents any facts or circumstances at or before the issuance of this policy and such misrepresentation constitutes a material misrepresentation under the applicable provisions of law, this policy will be void post-dated to inception.

Signature: _____

Date: _____