

**Supplemental Application for  
Dentists Part-Time Insurance Coverage**

Please return the completed application to [apply@mlmic.com](mailto:apply@mlmic.com) or fax (212) 576-9877

1. Name of Applicant: \_\_\_\_\_

2. Requesting Part-Time Coverage Effective: \_\_\_\_\_  
Month / Day / Year

**Your application for part-time coverage is subject to underwriting approval. A premium discount may be available to qualified dentists whose total practice to be covered under the MLMIC policy will not exceed twenty (20) hours in any given week.**

3. Please list all Professional Activities for which you require coverage under the MLMIC policy. Include all professional activity as a dentist, even if covered by other insurance.

Total Hours By Day Of Week

	In Office	Other	Hours to be covered by:		Total Hours
			(a) MLMIC	(b) OTHER	
Sun.					
Mon.					
Tue.					
Wed.					
Thur.					
Fri.					
Sat.					

(a) Of the hours in the grid above, how many hours and describe activities for which you require coverage under an individual MLMIC policy? \_\_\_\_\_Hours per week covered by a MLMIC Policy.

Activities: \_\_\_\_\_  
\_\_\_\_\_

(b) Of the total hours listed in the grid above, how many hours are, or will be, covered by other insurance and not by your individual MLMIC policy? \_\_\_\_\_Hours per week covered by other insurance. (If none, indicate "0").

Describe all activities covered by other insurance and name of insurance company(ies).  
\_\_\_\_\_  
\_\_\_\_\_

4. A reduced premium rate is conditioned upon an endorsement being attached to your policy excluding coverage for all other activities. The following restrictive language will be included in your policy.

**PART-TIME ENDORSEMENT**

It is agreed that, in reliance upon the Insured's written declarations and representations, and in consideration of the reduced rate of **Premium** at which this policy is written, the Insured's part-time practice to be covered by this policy will not exceed twenty (20) hours weekly.

No insurance is provided for the Insured's other dental practice activity that is covered by insurance issued by another company.

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.

**New York State Insurance Regulation 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."

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date