

AMERICAN DENTAL HYGIENISTS' ASSOCIATION
Application for Directors & Officers Claims-Made Coverage

Instructions: please type or print clearly.

Answer **ALL** questions completely. If any question, or part thereof, does not apply, insert "N/A" in the space provided and leave no blanks. Failure to answer all questions may delay our ability to provide your certificate of coverage, which may result in a gap of coverage. If you need more space, attach an additional page to this application and indicate the question number. This form must be completed, signed and dated by an Authorized Representative of the Local Organization applying for this insurance.

1. Full Name of Local Organization: _____

Mailing Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Contact Name: _____ **Phone #:** _____

Fax #: _____ **Email:** _____ **Website:** _____

2. During the past 5 years, has any claim been made, or is any claim now pending against your Affiliate, its Directors, Officers, or Employees? _____ Yes _____ No

3. Is any Director, Officer or Employee of your Affiliate aware of any situation, which may give rise to a claim being made against you or your local chapter? _____ Yes _____ No

If "yes" please give full details:

Coverage Limits: \$1,000,000 per claim/\$5,000,000 aggregate

Deductible: \$2500.

Annual Premium: \$424.00

To apply for coverage after 7/1/2019, please return completed application with the payment of **\$318.00**. This will represent 75% of the annual premium. The common expiration date is April 1st.

Make check payable to and mail to:

Mercer Health & Benefits Administration LLC
P.O. Box 310222
Des Moines, IA 50331-0222

If you have any questions, please contact Sally Cousineau at 312-627-6383 or email to:
sally.a.cousineau@mercer.com

Important Note:

Your coverage will become effective upon acceptance by the underwriters and receipt of your annual premium. In the absence of a specified effective date to replace current coverage, your coverage will become effective upon receipt of your application and payment. The expiration date of your policy will be **April 1, 2020**. This is an annual Blanket Directors & Officers policy with a common expiration date.

Signing this application does not bind the company to provide the insurance but it is agreed that this application will be part of the policy contract if a policy is issued.

Name: _____ **Signature:** _____ **Date:** _____
Please Print

In this transaction, Mercer Consumer, a service of Mercer Health & Benefits Administration LLC, (Mercer Consumer) is acting as the insurance agent and program manager for Great American Insurance Company, (“Insurer”) for this type of coverage, and not as your insurance broker. Alternative insurance products may be available in the insurance market place. Mercer is only offering this selected insurer quote proposal.

In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional nonmonetary compensation from insurers, or from other intermediaries, which may be contingent upon volume, profitability, or other factors. The insurance compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request.

You may obtain this information by referring to <https://personal-plans.com/disclosure> and enter in the security code o5035372 or call us at 1-888-206-5088 for specific details.