

LIBERTY DENTAL PLAN of NEVADA PRODUCER APPLICATION

Individual Producer Information

Producer Name _____
(Last Name) (First Name) (Middle Name)

Date of Birth ____/____/____ SSN ____-____-____ Email: _____

Phone # (____) _____ Ext. _____ Cell Phone # (____) _____ Fax # (____) _____

Business Address _____
STREET ADDRESS CITY STATE ZIP

Residence. Address _____
STREET ADDRESS CITY STATE ZIP

Organizational Producer Information (Agency) [You must complete if you are working with an agency]

Organization Producer Name _____

TIN ____ - ____ Taxpayer Type: Corp Sole Prop LLC LLP Other Entity _____

Phone # (____) _____ Ext _____ Fax # (____) _____ Email: _____

Mailing Address. _____
STREET ADDRESS CITY STATE ZIP

Business Address _____
STREET ADDRESS CITY STATE ZIP

Agency Contact Person _____

Phone # (____) _____ Ext _____ Fax # (____) _____ Email _____

Name of person (other than yourself) or of the agency to whom you will assign commissions _____

Assignment of commissions will not be effective until you complete a **Producer Assignment.**

License Information

State which issued you a resident producer license: _____ License # _____

Lines of Insurance for which you are currently licensed (check all that apply):

Life Health Other _____

LIBERTY

Dental Plan of Nevada
Individual Producer Licenses

STATE	LICENSE NUMBER	EFFECTIVE DATE	EXPIRATION DATE

LIBERTY DENTAL INSURANCE COMPANY PRODUCER APPLICATION

Organizational Producer Licenses

STATE	LICENSE NUMBER	EFFECTIVE DATE	EXPIRATION DATE

YOU MUST ATTACH A COPY OF EACH INDIVIDUAL AND ORGANIZATIONAL LICENSE LISTED ABOVE.

Please answer **Yes** or **No** to the following questions. If you answer **Yes** to any question, YOU MUST ATTACH A SEPARATE SHEET WITH AN EXPLANATION:

- | | | |
|---|------------------------------|-----------------------------|
| HAVE YOU EVER PLED GUILTY OR BEEN CONVICTED OF A FELONY OR MISDEMEANOR? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| DO YOU HAVE E&O INSURANCE COVERAGE? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HAS YOUR E&O INSURANCE COVERAGE EVER BEEN TERMINATED OR RESCINDED BY THE INSURER? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HAS ANY INSURER OR FINANCIAL INSTITUTION EVER TERMINATED ITS APPOINTMENT OF YOU OR ANY ORGANIZATION WITH WHICH YOU WERE ASSOCIATED "FOR CAUSE"? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HAVE YOU EVER BEEN DISCIPLINED BY ANY INSURANCE REGULATORY AUTHORITY? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HAVE YOU BEEN THE SUBJECT OF A BANKRUPTCY PETITION IN THE LAST SEVEN YEARS? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| DO YOU HAVE ANY JUDGMENTS OR LIENS AGAINST YOU? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| DO YOU OWE ANY AMOUNTS TO ANY INSURER, GENERAL AGENT, OR FINANCIAL SERVICE INSTITUTION THAT HAS REMAINED OVERDUE FOR MORE THAN 60 DAYS? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HAVE YOU EVER BEEN EXCLUDED, OR ARE YOU AWARE OF ACTIONS THAT COULD RESULT IN EXCLUSION, BY THE OIG FROM PARTICIPATION IN A GOVERNMENT HEALTH CARE PROGRAM, INCLUDING MEDICARE OR MEDICAID? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HAVE YOU EVER BEEN BARRED, OR ARE YOU AWARE OF ACTIONS THAT COULD RESULT IN DEBARMENT, BY THE GENERAL SERVICE ADMINISTRATION FROM BEING A GOVERNMENT CONTRACTOR? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE WITH THE FOLLOWING:

- (1) I may not place any business with Liberty Dental without the appropriate licensing and without a written appointment by Liberty Dental which requires that I enter into a written contract with Liberty Dental.
- (2) Liberty Dental Insurance Company, its affiliates, and/or outside entities may ask third parties about my credit history, character, business experience, personal characteristics, reputation, and insurance license status. I hereby authorize such information to be released to Liberty Dental or its legal representative.

- (3) A photocopy or facsimile of this signed authorization shall be as valid as the original.
- (4) Under penalty of perjury, I certify that information in this application or in any attached documents is correct and complete.
- (5) Under penalty of perjury, I certify that the taxpayer identification number on this application is mine and I am not subject to backup withholding.
- (6) If appointed by Liberty Dental or its affiliates, I agree that I will be an independent contractor, and not an employee Liberty Dental or its affiliates.

Individual Producer (Signature)

Date

Individual Producer (NAME PRINTED)

Organizational Producer (Name Printed)

Date

By: _____
(Signature of person signing on behalf of the organization)

Its: _____
(Title of person signing on behalf of the organization)