

## 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| HAS YOUR E&O INSURANCE COVERAGE EVER BEEN TERMINATED OR RESCINDED BY THE INSURER?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)