



## APPLICATION FOR LEAVE PERIOD ENDORSEMENT

Send the completed application and check to: American Acupuncture Council • 1851 E. First St, #1160 • Santa Ana CA 92705 • 800-838-0383

**A. Identifying Information** (Items 2 through 5 are listed on the Declarations to your Certificate.)

1. Print your name: \_\_\_\_\_
2. Certificate #: \_\_\_\_\_
3. Retroactive Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Not less than 12 mos prior to leave start)
4. Reason for Leave (describe nature of leave in detail): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Leave start date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
6. Expected leave end date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**B. Agreements** (To be read by applicant for leave coverage.)

1. **Cessation of Practice.** I understand and agree that there is no coverage for claims involving Professional Services that were rendered (or that should have been rendered and were not) during the Leave Period, and I agree not to perform Professional Services during the Leave Period. I understand that this Policy does afford coverage for a claim made or reported to the Company during the Leave Period but only where that claim involved the rendering or failure to render Professional Services prior to the Leave Period and only where the claim is otherwise covered under the terms of the Policy.
2. **Non-refundable Leave Period Premiums.** I understand and agree that the premium charged and paid for the Leave Period is non-refundable and nontransferable payment applicable only to the Leave Period regardless of the intended or actual length of the leave Period, i.e., regardless of whether the Leave Period lasts one day or up to the full one year.
3. **12-Month Maximum.** I understand and agree that the Leave Period must not exceed 12 months and, if not ended earlier, will end automatically twelve months after the beginning of the Leave Period.
4. **Prepayment of Resumed Full Coverage Premiums.** I understand and agree, in order to keep my Policy in effect, that, prior to the end of the Leave Period and prior to resuming Professional Services, I will prepay premiums to be applied toward full, resumed coverage, even if the Leave Period ends prior to the scheduled end of Leave Period date listed on this application and regardless of whether I receive a bill.
5. **Credits.** I understand that, at my request, unearned paid premium existed prior to payment of Leave Period premium may be applied toward purchase of Leave Period Coverage, and/or resumed full coverage.

**C. Agreements** (To be read by applicant for leave coverage)

**AGREEMENTS/NO FALSE STATEMENTS:** I understand that this is a non binding application for a Leave Period Endorsement. I understand and agree that the Agreements in this Application, once approved, shall become a binding part of the Leave Period Endorsement to my Policy. There are no false statements in this Application, and I understand that false statements will void coverage under the Leave Period Endorsement and Policy.

Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_