Professional SOLUTIONS

Request for Temporary Leave of Absence Endorsement

GENERAL INFORMATION

Name: _____
First Middle Initial Last

Policy Number: _____

Mailing Address: _____
Street Address City State Zip

Office Phone: _____ Fax: _____ Cell Phone: _____

Email: _____
Your email address will never be sold. It will be used to send you important messages.

SUSPENSION INFORMATION

1. Period of Suspension (minimum of 60 days, maximum of 180 days)

From: _____ To: _____

2. Reason for Suspension:

Please Note: If this request is due to medical reasons, please include an explanation from your doctor.

PLEASE READ, SIGN AND DATE

By signing this Request for Temporary Leave of Absence Endorsement I hereby verify that I am aware that coverage will NOT be provided for any claim that arises from an injury that occurred during the Period of Suspension noted above. I agree that I will not deliver adjustments during this Period of Suspension. I also understand that no changes can be made to this policy during this Period of Suspension.

Residents of Ohio: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Residents of Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing false, incomplete or misleading information is guilty of a felony.

Residents of all other states: 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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

Coverage offered by Professional Solutions Insurance Company.

X _____ **Date** _____
Signature

X _____ **Date** _____
Agent Signature

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Mail to:
14001 University Avenue
Clive, Iowa 50325-8258
Email: submissions@psicinsurance.com

Questions:
Phone: 800-788-8540
Fax: 800-510-6370