



Medical SecuritySM
PROTECTING OUR PROFESSION



Notification to add Locum Tenens Dentist:

Name of MSIC Insured Dentist for whom locum tenens dentist will be working:

_____ Policy # _____

Name of Locum Tenens Dentist: _____

NC Dental License Number: _____

Dates Locum Tenens Dentist worked in practice: _____

This notification must be received within 30 days of above dates in order for coverage to be effective.

***Please have the dentist for whom this locum tenens dentist substituted read and sign below:

Authorization by Substituted Insured Dentist – I hereby acknowledge and authorize Medical Security Insurance Company of NC to add the above named locum tenens dentist to my coverage for the dates noted above. I understand that I have no professional liability coverage for any professional services I might render or fail to render on these dates, and that the named locum tenens dentist will share in my Limits of Liability during such substitution. I further acknowledge that I am responsible for ensuring that the above-named dentist is, to the best of my knowledge, competent and that he/she possesses qualifications similar to my own.

Signature of Insured Dentist

Date