



Assignment of Unearned Premium

- 1. If the premium payer is other than the named insured, is this unearned premium assigned to the payer?
 - Yes. *Complete remainder of agreement; include both parties' signatures.*
 - No.

Agreement to Assign Unearned Premium

2. _____, hereinafter referred to as the Corporation and _____, referred to as the Medical Care Practitioner (MCP), hereby enter into this agreement.

- a) Whereas the Corporation has agreed with the MCP to pay the cost of professional liability coverage for the MCP during the current policy term beginning _____ and may do so for subsequent renewals, and;
- b) Whereas the premiums for professional liability insurance coverage for the MCP may be due and payable in advance for the policy period.

Now, therefore, the parties hereto agree to the following:

In consideration for the Corporation paying the premiums for said insurance, the MCP hereby:

- 1. Assigns and gives a security interest to the Corporation for any and all unearned premiums which may become payable from the professional liability policy paid for by the Corporation.
- 2. Irrevocably appoints the Corporation as the MCP's Attorney-In-Fact with full authority to cancel the MCP's professional liability policy purchased by the Corporation, receive all sums assigned to the Corporation or in which the MCP has granted the Corporation a security interest in furtherance of this agreement.
- 3. All legal rights given to the Corporation shall benefit the Corporation's successors and assigns and shall remain in effect until the MCP provides written notification of termination to both the Corporation and insurance company which issued the policy.
- 4. The MCP agrees not to further assign any interest in said professional liability policy without the Corporation's written consent.

Date _____

Date _____

Medical Care Practitioner Signature _____

Corporation _____

Print Name of Applicant _____

Officer _____

Home Address* _____

Address of Corporation _____

City, State, Zip* _____

Home Phone Number* _____

Witness to Medical Care Practitioner's signature _____

***This information will only be used for cancellation notification and Extended Reporting offers only.**