

DENTISTS PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)

1) Full Name of Applicant: Degree:

2) Principal Practice Address:

3) Additional Practice Locations:

4) Home Address:

5) Website Address

6) Social Security #:

7) DEA#

8) Date of Birth:

9) Place of Birth:

10) Are you a U.S. Citizen? YES NO

If NO, please indicate your status and date of entry into the United States:

11) From what Dental School did you graduate?

City, State and Country of Dental School

Degree: Year of Graduation:

If foreign medical school graduate, provide the date you began your practice in the United States:

12) Provide a detailed summary of where you have practiced since completing your training:

Address/City/State	Country	From	To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

13) Indicate memberships in professional societies:

14) List the States and License numbers where you practice.

15) Type of Practice (Check all that apply)

- Individual Employee Member of Multi-person Corp or Assoc*
 Individual Corporation * Partnership
Other

* Specify name of entity:

16) Do you want coverage for the entity named above? YES NO

17) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, please list the names of all dentists or oral surgeons practicing under the entity named above.

18) Do you practice with any dentists not named above? YES NO

If yes, provide the name of the dentists(s) and relationship to your practice:

19) Please provide the names of all facilities that you practice at and your interest in each facility.

Name of Clinic or Facility and Location Interest (Owner, Partner, Employee)

<u>Name of Clinic or Facility and Location</u>	<u>Interest (Owner, Partner, Employee)</u>
<input type="text"/>	<input type="text"/>

20) Are you seeking coverage for your work at all of the above facilities? YES NO

If No, please list those facilities for which you do not require coverage and explain why coverage is not needed.

21) Please provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage.

	<u># Employed</u>	<u># Contracted</u>	<u>Carry their own Med Mal policy?</u>
Dentists (other than yourself)	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Dental Assistants	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Dental Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Hygienists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Nurse Anesthetists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Anesthesiologists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Other: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO

Provide a description of duties, in detail, including extent supervised on separate page and attach protocols.

Please attach copies of dec pages on above professionals that carry their own malpractice policies.

22) Are all of the above individuals licensed in accordance with applicable state and federal regulations? YES NO

If No, please provide detailed explanation below.

23) a. What is your dental specialty?

b. Do you limit your practice to the above specialty? YES NO

If No, provide details:

24) Are you American Dental Board certified in any speciality? YES NO

If Yes, provide the Board(s) in which you are certified:

 Year:

25) What is your total annual revenue? \$100,000 or less \$250,000 - \$499,999
 \$100,001 - \$250,000 \$500,000 or more

26) Average weekly patient load: 27) Average number of hours you practice each week:

28) Please provide the approximate percentage of your practice in the following:

Bone Grafting	<input type="text"/>	
Cosmetic Dentistry	<input type="text"/>	
Bonding	<input type="text"/>	Veneers <input type="text"/>
Enamel Shaping	<input type="text"/>	Whitening with lasers <input type="text"/>
Full Mouth Restoration- Cosmetic Only	<input type="text"/>	

28) Continued

Other Cosmetic Procedures (describe below)

Endodontics

Single Rooted
 Multi Rooted
 Sargenti Root Canal Method

General Denistry

Extractions of Impacted Teeth
 Root Canal
 Simple Extractions Only

Implants

Restoration
 Placement

Microneurosurgical Procedures

Oral Pathology
 Oral Radiology
 Orthodontics
 Orthognathic Procedures
 Pediatric Dentistry
 Periodontics
 Prosthodontics

Non-Dental Cosmetic Procedures (including injecting Botox, collagen and fillers) (describe)

Prosthetics

Fixed
 Removable

Sleep Apnea

Surgery
 Therapy

Surgery

Facial - Elective Cosmetic
 Head and Neck
 Oral/maxillofacial
 Outside oral/maxillofacial region

* Please provide a complete list of all surgical procedures performed below.

TMJ

Non-surgical
 Surgery

Other (describe)

Total 100%

*List of Surgical Procedures:

29) Do you use written informed consent documents for all procedures? YES NO

If Yes, attach a copy of all forms that are used. If No, describe below.

30) Do you wire jaws closed for purposes of weight loss? YES NO

If Yes,

a) Number performed in the last 12 months

b) Estimated number that will be performed in the coming year

31) What percentage of your patients are under age 18?

32) Do you perform any hospital emergency room care? YES NO

If Yes, is this solely a requirement for active admitting privileges? YES NO

If No, provide a detailed description including the approximate number of hours per month spent in emergency room care.

33) If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed. (H= Hospital ; O = Office ; S = Surgi-Center or Certified Surgical Suite)

	Location		Location
<input type="checkbox"/> Acupuncture	<input type="text"/>	<input type="checkbox"/> Cheek Implant	<input type="text"/>
<input type="checkbox"/> Adenoidectomy/Tonsillectomy	<input type="text"/>	<input type="checkbox"/> Chemical Peel	<input type="text"/>
<u>Anesthesia:</u>		Solution Strength (specify) <input style="width: 120px;" type="text"/>	
<input type="checkbox"/> General	<input type="text"/>	<input type="checkbox"/> Chin Surgery	<input type="text"/>
<input type="checkbox"/> Twilight	<input type="text"/>	<input type="checkbox"/> Cleft Lip and Palate Surgery	<input type="text"/>
<input type="checkbox"/> Other-(describe) <input style="width: 150px;" type="text"/>	<input type="text"/>	<input type="checkbox"/> Cosmetic implantation of silicone or other material	<input type="text"/>
<input type="checkbox"/> Oral/Maxillofacial Surgery	<input type="text"/>	<input type="checkbox"/> Cosmetic Surgery	<input type="text"/>
<input type="checkbox"/> Other Surgery(describe)		<input type="checkbox"/> Cryosurgery	<input type="text"/>
<input style="width: 280px;" type="text"/>	<input type="text"/>	<input type="checkbox"/> Dental Alveolar Surgery	<input type="text"/>
<u>Extractions:</u>		<input type="checkbox"/> Dermabrasion/Microdermabrasion	<input type="text"/>
<input type="checkbox"/> Non-Impacted Teeth	<input type="text"/>	<input type="checkbox"/> Dermal Fillers	<input type="text"/>
<input type="checkbox"/> Impacted Teeth	<input type="text"/>	<input type="checkbox"/> Face Lift	<input type="text"/>
<u>Surgery and Other Procedures:</u>		<input type="checkbox"/> Hair Transplants or Suture of Hairpieces	<input type="text"/>
<input type="checkbox"/> Biopsies (describe) <input style="width: 150px;" type="text"/>	<input type="text"/>	<input type="checkbox"/> Laser Skin Resurfacing	<input type="text"/>
<input type="checkbox"/> Blepharoplasty	<input type="text"/>		
<input type="checkbox"/> Botox Injections	<input type="text"/>		

Surgery and Other Procedures (Continued)

- | | | | |
|--|--------------------------|---|--------------------------|
| <input type="checkbox"/> Laser Surgery (describe)
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> Pain Management (describe)
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Liposuction - above the neck (specify volume)
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> Radiation Therapy
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Liposuction - below the neck:
<input type="checkbox"/> under 3500 cc's volume
<input type="checkbox"/> 3500 cc's or more volume | <input type="checkbox"/> | <input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nerve Grafts | <input type="checkbox"/> | <input type="checkbox"/> Reconstructive Plastic Surgery (describe)
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Open Reduction of Fractures | <input type="checkbox"/> | <input type="checkbox"/> Rhinoplasty
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> Sargenti Root Canal Method
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> Sinus Lift
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> TMJ Surgery
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> Uvulopalatoplasty
<input style="width: 250px; height: 20px;" type="text"/> | <input type="checkbox"/> |

34) Is analgesia, sedation or anesthesia used on patients? YES NO

If Yes, do you administer Local Anesthesia ONLY? YES NO

If Local Anesthesia only, please continue to Q. 35.

If No, and you administer other types of anesthesia, PLEASE COMPLETE DENTIST'S ANESTHESIA SUPPLEMENTAL

- 35) Have you or any of your employees: YES NO
- A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? YES NO
- Attach a copy of Complaint and Consent order document if applicable.
- B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? YES NO
- C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you to be evaluated for an alleged mental condition and/or alcohol or drug addiction? YES NO
- D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked renewal refused or accepted only on special terms or ever voluntarily surrendered same? YES NO
- E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? YES NO
- F. Ever failed any medical licensing or specialty organization examination? YES NO

G. Do you have any chronic illnesses or defects?

YES NO

If Yes to any of the above questions, please provide full details below.

36) Do you anticipate any changes in your practice?

YES NO

If Yes, please describe below.

37) List the prior medical malpractice insurance carried for each of the past 5 years beginning with most current:

<u>Insurance Company</u>	<u>Limits Of Liability</u>	<u>Policy Period</u>	<u>Premium</u>	<u>Retro Date</u>

* Attach a copy of the declarations page of your most recent policy.

38) Do you own, operate or provide professional services for, or at, any dental or health care facility or business enterprise not already clearly described in this application?

YES NO

If Yes, please describe:

39) Has any claim or suit for alleged malpractice been brought against you? YES NO

If Yes, how many total claims or incidents:

Please complete the Supplemental Claim Information Form for this application for each and every claim. Also please attach 10 years of currently valued company loss runs.

40) Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? YES NO

If Yes, Please complete the Supplemental Claim Information Form for this application for each and every claim.

41) Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? YES NO

If Yes, please include details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident.

I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Current Date:

Title

If you prefer not to Return Application with an Electronic Signature, Please print and Sign Below:

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this electronically submitted application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this electronic application and this application will be made part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Signature of Applicant or Authorized Representative

Current Date:

Title

Please attach copies of the following documents:

CV or Resume

Five years of currently valued company loss runs

Copies of any disciplinary actions, stipulations orders or probation documents

Copies of declaration pages for all employees or contractors that carry their own med mal

Copy of applicant's most current declarations page

Additional Comments or Details: