



DENTIST'S PROFESSIONAL LIABILITY APPLICATION

(CLAIMS MADE AND REPORTED COVERAGE)

1) Full Name of Applicant:

2) Degree:

3) Principal Practice Address:

4) Additional Practice Locations:

5) Home Address:

6) Website:

7) Social Security Number:

8) DEA Number:

9) Date of Birth:

10) Place of Birth:

11) Are you a U.S. Citizen? Yes No

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

12) 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:

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

Address/City/State	Country	From	To

14) Indicate memberships in professional societies:

15) List the States and License numbers where you practice:

16) Type of practice (Check all that apply):

Individual Employee Individual Corporation Partnership

Member of Multi-person Corp or Assoc. – Specify Name of Entity:

Other:

17) Do you want coverage for the entity named above? Yes No

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

19) Do you practice with any dentists not named above? Yes No

If yes, provide the name of the dentist(s) and relationship to your practice?

20) 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)

21) Are you seeking coverage for your work at all of the above facilities? Yes No

If no, list those facilities for which you do not require coverage and explain why coverage is not needed:

22) Provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage:

	Number Employed	Number Contracted	Carry their own Med Mal Policy?
Dentists (other than yourself)			Yes No
Dental Assistants			Yes No
Dental Technicians			Yes No
Hygienists			Yes No
Nurse Anesthetists			Yes No
Anesthesiologists			Yes No
Other:			Yes No

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

Attach copies of Dec Pages on above professionals that carry their own malpractice policies.

23) Are all of the above individuals licensed in accordance with the applicable state and federal regulations? Yes No

If no, provide a detailed explanation below:

24) What is your dental specialty?

Do you limit your practice to the above specialty? Yes No

If no, provide details:

25) Are you American Dental Board certified in any specialty? Yes No

If yes, provide the Board(s) in which you are certified below: Year:

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

27) Average weekly patient load:

28) Number of hours you practice each week:

29) Provide the approximate percentage of your practice in the following:

Bone Grafting	%	Pediatric Dentistry	%
Cosmetic Dentistry		Periodontics	%
Bonding	%	Prosthodontics	%
Enamel Shaping	%	Non-Dental Cosmetic Procedures (including injecting Botox and collagen fillers)	
Full Mouth Restoration - Cosmetic Only		Describe:	%
Veneers		Prosthetics	
Whitening with Lasers	%	Fixed	%
Other:	%	Removable	%
Endodontics		Sleep Apnea	
Single Rooted	%	Surgery	%
Multi Rooted	%	Therapy	%
Sargenti Root Canal Method	%	Surgery*	
General Dentistry		Facial – Elective Cosmetic	%
Extractions of Impacted Teeth	%	Head and Neck	%
Root Canal	%	Oral/maxillofacial	%
Simple Extractions Only	%	Outside oral/maxillofacial region	%
Implants		TMJ	
Restoration	%	Non-surgical	%
Placement	%	Surgery	%
Micro Neurosurgical Procedures		Other:	%
Oral Pathology	%		
Oral Radiology	%		
Orthodontics	%		
Orthognathic Procedures	%	TOTAL	100%

*Provide complete list of surgical procedures

30) 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:

31) 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?

32) What percentage of your patients are under age 18? %

33) 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 yours per month spent in emergency room care:

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

Procedure	Location	Procedure	Location
Acupuncture		Chemical Peel	
Adenoidectomy/Tonsillectomy		Solution Strength:	
Anesthesia:		Chin Surgery	
General		Cleft Lip and Palate Surgery	
Twilight		Cosmetic Implant of Silicone or other Material	
Other:		Cosmetic Surgery	
Surgery Other:		Cryosurgery	
Extractions:		Dental Alveolar Surgery	
Non-Impacted Teeth		Dermabrasion/Microdermabrasion	
Impacted Teeth		Dermal Fillers	
Surgery and Other Procedures:		Face Lift	
Biopsies:		Hair Transplants or Suture of Hairpieces	
Blepharoplasty		Laser Skin Resurfacing	
Botox Injections		Pain Management (describe):	
Laser Surgery (describe):			
		Radiation Therapy	
Liposuction – above the neck (volume):		Radiopaque Dye Injections into blood vessels, lymphatics, sinus tracts or fistulae	
		Reconstructive Plastic Surgery (describe):	
Liposuction – below the neck:			
Under 3500 cc's volume		Rhinoplasty	
3500 cc's or more volume		Sargenti Root Canal Method	
Nerve Grafts		Sinus Lift	
Open Reduction of Fractures		TMJ Surgery	
Cheek Implant		Uvulopalatoplasty	

35) 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 Q36.
 If no, and you administer other types of anesthesia, complete a [Dentist's Anesthesia Supplemental Application](#).

36) Have you or any of your employees:

- a. Ever been the subject of investigation 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, provide full details below:

37) Do you anticipate any changes in your practice? Yes No
 If yes, describe below:

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

Company	Limit	Deductible	Premium	Policy Term	Retro Date

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

39) 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, describe:

40) Has any claim or suit for alleged malpractice been brought against you? Yes No

If yes, how many total claims or incidents?

Also attach 5 years of currently valued company loss runs.

41) 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, complete the [Supplemental Claim Information Form](#) for each and every claim.

42) Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being brought against you? Yes No

If yes, provide details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident:

Please attach the following information:

- CV or Resume
- Five years of currently valued carrier loss runs
- Copies of any disciplinary actions, stipulations, orders or probation documents
- Copies of declarations pages for all employees or contractors that carry their own med mal
- Copy of applicant's most current declarations page

Provide any additional comments or details on a separate attachment.

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

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 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:

Title:

Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.