Dental Professional Liability Insurance—Claims-Made Dentist Application

DentistCare℠

ProAssurance Treated Fairly

ProAssurance Indemnity Company, Inc. • PO Box 590009 • Birmingham, AL 35259-0009 • 800.625.7814 • Fax 205.868.4040

With your fully completed, signed and dated application, you must submit the following information:

1. Current insurance policy declarations page.
2. Copy of extended reporting endorsement (tail) from your current carrier if your current coverage is claims-made and you are *not* applying for Prior Acts Coverage.
3. Loss runs from all prior insurance companies or explanation as to why they are not available.
4. Current business letterhead.

1. Personal Information

Name: _____ Degree: _____

Date of Birth: _____ Social Security Number: _____ Gender: Male ☐ Female ☐

Email Address: _____

Home Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Dental License Number(s):	State	License Number	Expiration Date	% of Practice

Professional Membership(s): ☐ ADA (membership level): _____

☐ AGD (membership level): _____

☐ Other: _____ Membership #: _____

2. Practice Location

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Billing Address: _____

Contact Name: _____ Title: _____

Contact Email Address: _____

Please list other practice locations:

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Dates: _____ From: _____ To: _____ Percent of Practice: _____

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Dates: _____ From: _____ To: _____ Percent of Practice: _____

3. Coverage Requested

A. Requested effective date: _____ / _____ / _____
MONTH DAY YEAR

B. Please indicate your desired level of coverage.
Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): _____ / _____
Excess Coverage Limits (where available): _____

C. Do you desire coverage for a practice entity? Yes ☐ No ☐
If yes, we require a corporate application to be completed.

4. Prior Acts Coverage

(Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.)

A. Are you requesting Prior Acts Coverage? If no, please skip to Section 5. Yes ☐ No ☐
Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

B. During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g., different states, procedures, coverages, etc.). Yes ☐ No ☐
If yes, please describe the changes in your practice, including all applicable dates in the space at the end of the application.

5. Education and Training

A. Please list the name and location of all dental schools attended:

Institution and Location	Dates Attended	Degree Obtained

B. Please list any post-graduate training:

Institution and Location	Dates Attended	Degree Obtained

C. Are you board certified in any specialty or have you completed a General Practice Residency? ☐ Yes ☐ No
If yes, please list board certified specialty GPR: _____

6. Practice Information

A. Do you practice as (check one):

☐ Solo Unincorporated ☐ Partner in a Partnership ☐ Employee
☐ Solo Corporation ☐ Shareholder in a Professional Corporation ☐ Independent Contractor

B. Please check and indicate percentage of time you practice in each. Total must equal 100%:

☐ General Dentistry _____% ☐ Pediatric Dentistry _____% ☐ Endodontics _____%
☐ Periodontics _____% ☐ Oral or Maxillofacial Surgery _____% ☐ Prosthodontics _____%
☐ Orthodontics _____% ☐ Oral Radiology _____% ☐ Oral Pathology _____%
Other _____%

C. Please check and indicate procedures you perform and percent of your practice (total must equal 100%):

Cosmetic: ☐ Intra-oral _____% ☐ Extra-oral (Botox/dermal fillers and similar procedures) _____%

Oral Surgery: ☐ Minor (Alveolar) _____% ☐ Major (other procedures) _____%

Extractions: ☐ Simple _____% ☐ Full Impacted _____% ☐ Partial Bony Impacted _____%

Do you do third molar extractions? ☐ Yes ☐ No

Implants: ☐ Initial Surgical _____% ☐ Restorations _____%

Endodontics: ☐ Single-rooted endodontics _____% ☐ Multi-rooted endodontics _____%

Prosthodontics: ☐ Single unit bridge/crown _____% ☐ Multi-unit bridge/crown _____%

☐ Full mouth dentures _____% ☐ Denture adjustment and repair _____%

Periodontics: ☐ Scaling/root planing _____% ☐ Soft tissue surgery _____%

☐ Soft tissue grafts _____% ☐ Bone grafts _____%

Orthodontics: ☐ Comprehensive orthodontics _____% ☐ Minor tooth guidance _____%

Pain Management: ☐ Treatment of TMD _____% ☐ Other (describe) _____ _____%

Other: ☐ Surgical procedures _____%

☐ Non-surgical procedures _____% Describe: _____

If none of the above procedures apply to your practice, please initial here: _____

D. Anesthesia/Sedation

1. Check the type of anesthesia and/or sedation used in your practice and number of procedures done per year in an office or hospital practice, and who administers the anesthesia/sedation.

☐ Local and/or Nitrous Oxide Only
In Office _____ In Hospital _____
Who Administers: _____

☐ IV/IM Moderate Sedation
In Office _____ In Hospital _____
Who Administers: _____

☐ Oral Moderate Sedation (sedation dentistry)
In Office _____ In Hospital _____
Who Administers: _____

☐ General Anesthesia
In Office _____ In Hospital _____
Who Administers: _____

*Please note: If you checked IV/IM sedation, oral moderate sedation, or general anesthesia, we may require a supplemental application to be completed.

2. Please indicate your certification information:
☐ ACLS ☐ BCLS ☐ PALS

3. Do you require that your staff be certified (ACLS, BCLS, or PALS)? ☐ Yes ☐ No

E. How many hours a week do you practice? _____ Date you established this schedule: _____ (MONTH) / _____ (DAY) / _____ (YEAR)

F. Do you teach in a dental school? ☐ Yes ☐ No
If yes, indicate how many hours per week and if coverage is provided through the dental school in the space provided at the end of the application.

G. Do you treat or review treatment of inmates in a correctional institution? ☐ Yes ☐ No
If yes, list the correctional institution, percent of your total practice time, and if coverage is provided through the facility in the space provided at the end of the application.

H. Do you treat patients via a mobile dental unit? ☐ Yes ☐ No
If yes, please list percent of your total practice time: _____%

I. Do you treat or review treatment of patients in a nursing home facility? ☐ Yes ☐ No
If yes, please list percent of your total practice time: _____%

J. Do you treat sleep apnea patients? ☐ Yes ☐ No
If yes, do you ever treat without a physician referral? ☐ Yes ☐ No

K. Do you perform any procedures that are clinical trials, experimental, not usual or customary to the specialty or that are not approved by the ADA or the FDA? ☐ Yes ☐ No
If yes, describe in the space provided at the end of the application.

L. Do you provide elective facial cosmetic procedures, Botox, collagen injections, or other dermal fillers for cosmetic purposes in your practice? ☐ Yes ☐ No

M. Do you perform procedures outside the oral and maxillofacial region? ☐ Yes ☐ No
If yes, describe procedures and number provided per year in the space provided at the end of the application.

N. Do you provide forensics or expert witness testimony? ☐ Yes ☐ No

7. Insurance History and Claim Information

A. Current Insurance Information:

i. Name of Insurer: _____

ii. State Where Practiced: _____

iii. Policy Limits: _____

iv. Dates Covered, From: _____ To: _____

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Previous Insurance Information:

i. Name of Insurer: _____

ii. State Where Practiced: _____

iii. Policy Limits: _____

iv. Dates Covered, From: _____ To: _____

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

C. Previous Insurance Information:

i. Name of Insurer: _____

ii. State Where Practiced: _____

iii. Policy Limits: _____

iv. Dates Covered, From: _____ To: _____

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

D. Will you be carrying additional liability insurance with another company? Yes ☐ No ☐

If yes, provide name of company, limits, expiration date, and services covered in the space provided at the end of the application.

If you answer yes to questions E, F, or G, including any sub-questions, please complete the attached Supplementary Claims Information Form.

E. Have you *ever* been involved in a dental professional liability claim or suit? The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership. Yes ☐ No ☐

F. Other than the situations indicated in 7.E. above, are you aware of any of the following circumstances:

i. A request for records from a patient, family member, attorney, or patient representative related to an adverse outcome or treatment of a patient? Yes ☐ No ☐

ii. A letter from an attorney regarding your treatment of a patient? Yes ☐ No ☐

iii. A patient, family member, or patient representative's dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes ☐ No ☐

iv. Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes ☐ No ☐

G. Have all circumstances in question 7.F. above been reported to your current or prior professional liability carrier? Yes ☐ No ☐ N/A* ☐

If yes, how many? _____ Please attach documentation of all such reports.

If no, please explain in space provided at the end of the application.

*For purposes of this question, N/A means that you answered "No" to each subpart of question 7.F.

H. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? *This question is not applicable in Missouri.* Yes ☐ No ☐

8. Personal History

(If you answer yes to any of the following questions, provide complete details in the space provided at the end of the application or on a separate sheet.)

A. Have you ever been treated for alcoholism, drug addiction, sexual addiction, or mental illness? Yes ☐ No ☐

B. Are you aware of, or in a treatment program for, any health impairment or disability that may affect your ability to perform professionally? Yes ☐ No ☐

C. Have you ever been convicted of, pled guilty to, or pled no contest to a felony? Yes ☐ No ☐

D. Have you ever been convicted of, pled guilty to, or pled no contest to a violation of any law or ordinance (other than minor traffic offenses), including driving while under the influence of alcohol or any other substance? Yes ☐ No ☐

E. Have you ever failed any licensing or Board Certification examinations? Yes ☐ No ☐

F. Has your license to practice dentistry or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? Yes ☐ No ☐

G. Have you ever appeared before, been investigated by, or entered into any consent agreement with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes ☐ No ☐

H. Have you ever had a patient or patient representative complain to or file a grievance of any type with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes ☐ No ☐

I. Have you ever voluntarily surrendered your hospital privileges, narcotics or professional license to avoid suspension, restriction, probation, or revocation? Yes ☐ No ☐

J. Has any hospital ever restricted, suspended, revoked, or refused your privileges or has probation ever been invoked? Yes ☐ No ☐

K. Have you ever been accused of sexual misconduct or inappropriate physical contact? Yes ☐ No ☐

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Texas Purchasing Group Intent to Join

The undersigned insured hereby consents to join the American Dental Professional Liability Purchasing Group, a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

Virginia Purchasing Group Intent to Join

The undersigned insured hereby consents to join the ProAssurance Healthcare Providers Purchasing Group, a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Applicant's Signature: _____ Date: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information section which requires your signature. Please read it carefully.

Authorization to Release Information

I, the undersigned hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance upon its request, any information which in the judgment of any such person noted above, may have bearing upon my acceptability to ProAssurance as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photo copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

Dentist's Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Name: _____
2. Date Reported to Insurance Company: _____
3. Name of Insurance Company: _____
4. Name and Address of the Attorney Assigned to Your Case: _____
5. Date of Incident and Your Treatment: _____
6. Allegations: _____

   _____

   _____
7. What is the present condition of the patient? _____

   _____

   _____
8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes ☐ No ☐
9. Status of claim (check applicable answer):

☐ Suit threatened, no action taken	☐ Court outcome in your favor	☐ Awaiting mediation
☐ Suit filed, but dropped by claimant	☐ Jury verdict	☐ Awaiting court action
☐ Summary Judgment in your favor	☐ Directed verdict	Reserve Amount: _____
☐ Suit settled Out-of-Court	☐ Court outcome in favor of plaintiff	
Date claim paid: _____	☐ Jury verdict	
Amount paid: _____	☐ Directed verdict	
	Amount of Loss: _____	

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐
    If yes, amount was: $_____

Name (Printed): _____

Signature: _____ Date: _____