

Dental Professional Liability Insurance—Claims-Made Dentist Application

DentistCareSM

PROASSURANCE
Treated Fairly

ProAssurance Casualty Company • 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: _____

Kentucky Only: Professional office located within the city limits of: _____

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):
- | | | |
|--|--|---|
| <input type="checkbox"/> Solo Unincorporated | <input type="checkbox"/> Partner in a Partnership | <input type="checkbox"/> Employee |
| <input type="checkbox"/> Solo Corporation | <input type="checkbox"/> Shareholder in a Professional Corporation | <input type="checkbox"/> Independent Contractor |
- B. Please check and indicate percentage of time you practice in each. Total must equal 100%:
- | | | |
|---|---|--|
| <input type="checkbox"/> General Dentistry _____% | <input type="checkbox"/> Pediatric Dentistry _____% | <input type="checkbox"/> Endodontics _____% |
| <input type="checkbox"/> Periodontics _____% | <input type="checkbox"/> Oral or Maxillofacial Surgery _____% | <input type="checkbox"/> Prosthodontics _____% |
| <input type="checkbox"/> Orthodontics _____% | <input type="checkbox"/> Oral Radiology _____% | <input type="checkbox"/> 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.

- | | |
|---|---|
| <input type="checkbox"/> Local and/or Nitrous Oxide Only
In Office _____ In Hospital _____
Who Administers: _____ | <input type="checkbox"/> IV/IM Moderate Sedation
In Office _____ In Hospital _____
Who Administers: _____ |
| <input type="checkbox"/> Oral Moderate Sedation (sedation dentistry)
In Office _____ In Hospital _____
Who Administers: _____ | <input type="checkbox"/> 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? 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.

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.

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
- Suit filed, but dropped by claimant
- Summary Judgment in your favor
- Suit settled Out-of-Court
Date claim paid: _____
Amount paid: _____

- Court outcome in your favor
 - Jury verdict
 - Directed verdict
- Court outcome in favor of plaintiff
 - Jury verdict
 - Directed verdict
- Amount of Loss: _____

- Awaiting mediation
- Awaiting court action
- Reserve Amount: _____

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: _____