Application for Claims-Made Coverage Professional & Dental Business Liability Insurance

The Dentists Insurance Company
1201 K Street, 17th Floor, Sacramento, CA 95814

Please type or print
Please read this before filling out your application for Professional & Dental Business Liability Insurance.
You represent that the following statements are yours and that you know the statements to be true. You know and intend that we will rely on the truth of the information you have provided in deciding to issue a policy to you.

Desired Coverage Date: _____ / _____ / _____ **Retroactive Date:** _____ / _____ / _____

1. Contact and Other Professional Information

Last Name First Name M.I.

Professional Degree ☐ DDS ☐ DMD ☐ Other Birth Date _____ / _____ / _____

Primary Practice Location (where you practice *the majority* of the time)

Mailing address, if different from practice address

Do you own your own practice? ☐ Yes ☐ No Tax ID # _____# of locations where you practice _____

SSN | Email Address | Practice Website

Office Phone No. | Alternate Phone No. | Fax No.

Dental License No. | State | Exp. Date

Dental School | Year Graduated | Year First Began Practicing in U.S.

Please list all other states in which you have held a dental license below:

☐ Not licensed in any other states.

State	Have you practiced in this state?	Do you have plans to practice in this state?	Dates of practice from mm/yy to mm/yy
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

Additional Comments: _____

2. Type of Practice

a. Have you completed a General Practice Residency (GPR) or an Advanced Education in General Dentistry (AEGD) Program? ..... ☐ Yes ☐ No

Name of Hospital Year Completed

b. Have you completed a Specialty Program? ..... ☐ Yes ☐ No

Specialty Specialty School Attended Year Specialty Training Completed

c. Do you perform or provide any of the following services? Please check all that apply.

☐ Blood Compatibility Tests ☐ Chelation Therapy ☐ Cosmetic Surgery ☐ Dermal Fillers (like Botox®)

☐ Homeopathic Therapies ☐ Liposuction ☐ NICO (neuralgia-inducing cavitational osteonecrosis) Treatments

☐ Online Orthodontia ☐ Teledentistry ☐ Vaccines ☐ None of the above.....

*If **yes**, please provide details.*

d. How many hours per week on average do you plan to practice dentistry over the next year? _____

e. Are you a full-time member of a dental school faculty? .....☐ Yes ☐ No
*If **yes**, you must attach a letter from the school verifying your full-time appointment to receive the faculty discount.*

f. Are you a full-time student enrolled in an accredited dental postgraduate program? .....☐ Yes ☐ No
*If **yes**, you must attach a letter from the school verifying your full-time student status to receive the postgraduate discount.*

g. In what capacity do you provide professional services?

☐ Owner ☐ Employee ☐ Ind. Contractor

☐ Other, please describe: _____

h. Have you completed a professional liability risk management/loss prevention course in the last two (2) years? .....☐ Yes ☐ No

*If **yes**, please list course title, sponsor, length of program and date completed.*

3. State Dental Association or Society

Are you a member or applicant of your state dental association or society? .....☐ Yes ☐ No

ADA No. Local Dental Society

4. Please provide the name(s) of your professional liability carrier(s) **for the past five years**, including policy period and type of policy. *All information must be provided, not just a copy of your current policy declarations.*

Insurance Company	Certificate/Policy No.	Coverage Dates	Type of Policy (O=Occurrence/CM=Claims-Made)

Attach a copy of your most recent insurance declarations page(s), including your prior acts or retroactive date.

5. Are you now practicing or have you ever practiced without professional liability insurance? .....☐ Yes ☐ No

If yes, please give details including the dates between which you were uninsured.

6. Has any insurer, including TDIC, ever declined an application for coverage or rescinded, cancelled, modified coverage (i.e. reduced limits, assigned a deductible, restricted coverage, or surcharged rates) or refused renewal of your professional liability insurance for any reason? .....☐ Yes ☐ No

If yes, please give details and provide copies of all notices of cancellation, non-renewal, declination or coverage modification.

7. Do you treat patients under any of the anesthetic modalities listed below?

☐ None ☐ Local anesthesia ☐ N_2O/O_2 analgesia ☐ Oral conscious sedation

☐ Conscious sedation (including IV or IM) or general anesthesia in a hospital or surgicenter, administered by a dentist anesthesiologist, M.D. anesthesiologist, CRNA or oral and maxillofacial surgeon

☐ Conscious sedation (including IV or IM) in office

Name of person administering anesthesia: _____

Specialty? _____ License #: _____

☐ General anesthesia in office

Name of person administering anesthesia: _____

Specialty? _____ License #: _____

8. Does your practice include spa dentistry? ..... ☐ Yes ☐ No

9. Do you perform sleep apnea/snoring therapy? ..... ☐ Yes ☐ No

*If **yes**, do you treat **only** after a physician's referral?* ..... ☐ Yes ☐ No

10. Desired limit of liability – Check one only

☐ $500,000 per occurrence/$1,500,000 aggregate per policy year

☐ $1,000,000 per occurrence/$3,000,000 aggregate per policy year

☐ $1,500,000 per occurrence/$4,500,000 aggregate per policy year

☐ $3,000,000 per occurrence/$3,000,000 aggregate per policy year

☐ $5,000,000 per occurrence/$5,000,000 aggregate per policy year

11. Do you practice as a partner in a dental partnership? ..... ☐ Yes ☐ No

_____

*If **yes**, name of partnership.*

12. Do you practice as an officer, director, or shareholder of a dental corporation with multiple owners? ..... ☐ Yes ☐ No

_____

*If **yes**, name of corporation (*not applicable to sole corporations).*

13. Type of Identity Recovery Coverage desired? (Optional) ..... ☐ Individual ☐ Family ☐ None

14. Has any licensing or other governmental agency ever investigated you, suspended or revoked your license, placed you on probation, imposed any fine or penalty or taken any other action against you related to your practice of dentistry? ..... ☐ Yes ☐ No

_____

*If **yes**, please give details.*

15. Have you ever been convicted of a crime, or are you currently charged with a crime, other than minor traffic violations? ..... ☐ Yes ☐ No

_____

*If **yes**, please give details.*

16. Have you ever been charged with fraudulent billing or other wrongdoing by Medicare, Medicaid or other third-party payor of dental treatment fees or charges? ..... ☐ Yes ☐ No

*If **yes**, please give details.*

17. Do you have any personal health problems that could reasonably be expected to affect the care you provide patients or your ability to manage your practice, including but not limited to any chronic or continuing health condition or treated/untreated alcoholism, narcotics addiction or mental illness? ..... ☐ Yes ☐ No

*If **yes**, please attach a statement from your treating physician regarding the status of your health problem(s).*

18. Within the preceding five years has any claim or allegation of malpractice, or other wrongdoing in rendering or failing to render professional services, been asserted against you? ..... ☐ Yes ☐ No

*If **yes**, complete one form for each claim, suit, allegation or incident. Please photocopy this section, if necessary. Answer all questions completely.*

Name of patient/claimant _____ City/State where incident occurred _____

Allegation _____

Were you insured: ..... ☐ Yes ☐ No Name of Insurer: _____

Date(s) of alleged occurrence _____ Date incident/claim/suit reported to insurance company _____

Current Status _____

If open, amount of reserve _____ if closed, amount of total settlement or judgment _____ Date closed _____ Amount paid on your behalf _____

Please provide a narrative description of the claim or allegations, including nature of treatment, your involvement, etc. If no payment was made, how was the matter concluded? (Please attach additional sheets as needed.)

19. Other than as disclosed above, are you aware of any complaint, demand, dispute, injury, adverse treatment outcome or other incident(s) that you have reason to believe could give rise to a claim in the future? ..... ☐ Yes ☐ No

*If **yes**, please give details and provide documentation of your notice of such matter(s) to your current insurer, if any.*

EXCLUSION

Any policy issued in response to this application will exclude liability based on, arising out of or attributable to any allegation, claim or incident you are required to but did not disclose in response to Questions 18 and 19 above.

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1201 K Street, 17th Floor, Sacramento, CA 95814

Employment Practices Liability Insurance (Optional Coverage)
Please read these notices before filling out your application for Employment Practices Liability Insurance.

DEFENSE COSTS (INCLUDING ATTORNEY'S FEES AND COSTS) **WE** PAY FOR THE DEFENSE OF COVERED **CLAIMS** UNDER THIS COVERAGE (IF PURCHASED) REDUCE **OUR** LIMIT OF LIABILITY FOR COVERAGE D. THE MORE **YOU** SPEND TO DEFEND THE **CLAIM**, THE LESS **YOU** WILL HAVE AVAILABLE TO PAY ANY SETTLEMENT OR JUDGMENT AGAINST **YOU**.

Employment Practices Liability coverage, if provided in response to this Application, will apply ONLY to those claims for employment related acts which, at the beginning of the policy period, you could not reasonably have foreseen giving rise to a claim during the policy period. Further, the policy will exclude any claim based upon, arising out of or attributable to any act, omission, fact or circumstances required to be disclosed in this Application, or in any later renewal questionnaire, whether or not you actually disclose the required information in the application or in some other manner before the policy is issued.

Desired Limit of Liability (check one) ☐ $50,000 ☐ $100,000 ☐ Coverage not desired

1. Is this coverage replacing an existing Employment Practices Liability policy? ..... ☐ Yes ☐ No
*If **yes**, please include a copy of your current Employment Practices Liability Insurance declaration page including your Employment Practices Liability prior acts or retroactive date.*

2. Number of employees at all locations excluding family members:

	Full Time	Part Time
Hygienists		
Dental Assistants		
Partners or Shareholders		
Other Office Staff		
Other Dentists Who Are Independent Contractors or Employees		

3. Do any of the employee dentists above work under a contract that gives them the right to take over the practice? ..... ☐ Yes ☐ No

4. Have you terminated, demoted, or disciplined an employee or independent contractor within the past five (5) years? ..... ☐ Yes ☐ No
*If **yes**, please list the employee or independent contractor's name, date and give a brief explanation of the action taken.*

_____

_____

5. Has anyone made any employment-related accusations, allegations, claims, complaints, or filed any suit or other legal proceeding against you in the past five years? ..... ☐ Yes ☐ No
*If **yes**, then please list each one by the name of the employee and the nature of the accusation, allegation, claim, suit, complaint or legal proceeding. Include the amount of any settlement or judgment and its date.*

_____

_____

6. During the last 5 years, has any insured been the subject of, or party to, any lawsuit, charges, inquiries, investigations, grievances or other proceedings before any federal or state agencies related to any employment-related matter including, but not limited to: the National Labor Relations Board, the Equal Employment Opportunity Commission, the U.S. Department of Labor, and state or local agencies enforcing laws related to wages and hours, working conditions, workplace safety, discrimination and harassment, and workers' compensation? ☐ Yes ☐ No

*If **yes**, please explain.*

7. Other than as stated above, are you aware of any other employment-related incidents that you have reason to believe could result in a claim in the future? ☐ Yes ☐ No

*If **yes**, please provide the employee's name and the date and details of the incident.*

8. Has any insurer ever rescinded, cancelled, declined or refused renewal of your employment practices liability insurance? ☐ Yes ☐ No

*if **yes**, please provide details.*

9. In your office, do you have written procedures in place with regard to the following:

Termination ☐ Yes ☐ No
Hiring ☐ Yes ☐ No
Discipline ☐ Yes ☐ No
Do you have a standard employment application for all applicants? ☐ Yes ☐ No
Do you have an employee handbook? ☐ Yes ☐ No
Do you have an "At Will" provision in the employment application or handbook? ☐ Yes ☐ No
Do you have a written policy with respect to sexual harassment? ☐ Yes ☐ No
Do you have a written policy with respect to discrimination? ☐ Yes ☐ No
Do you have written annual performance evaluations for employees? ☐ Yes ☐ No
If **yes**, are the evaluation documents signed by the employees? ☐ Yes ☐ No
Do you have written procedures for handling employee complaints regarding harassment or discrimination? ☐ Yes ☐ No
Do you post the required federal and state posters and notices? ☐ Yes ☐ No

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AUTHORIZATION

I authorize release and exchange of information between my past and present dental society, the state dental association or society and their insurance consultants, any hospital where I presently hold or previously held staff privileges, prior professional liability insurance carriers and their agents, previous attorneys of record in any liability actions or claims, any government agency, and The Dentists Insurance Company (TDIC) involving past or future underwriting and claims matters. I hereby represent the truth of my statements and representations made herein, and that I have not withheld any information that is reasonably likely to influence the judgment of the company in considering this application for professional & dental business liability insurance and/or employment practices liability insurance. SIGNING THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE CONTRACT. HOWEVER, IF A POLICY IS ISSUED, THIS APPLICATION WILL BECOME PART OF THE POLICY.

I agree to notify TDIC of any change in the information contained in this application – before and after a policy is issued – and to supply such further underwriting information as TDIC may require.

I hereby certify that I have reported to my present or previous insurance carriers all known claims and all incidents which I have reason to believe could give rise to future claims, and have disclosed all such information in this application.

Print Name	Signature of Applicant	Date (mm/dd/yy)

Return this application by mail or fax.

Mail to: The Dentists Insurance Company
1201 K Street, 17th Floor
Sacramento, CA 95814

Fax to: 916.554.5957

To apply online: tdicinsurance.com

Questions? Call your local broker:

Alaska – 907.276.7667, Conrad-Houston Insurance
Arizona – 800.733.0633, TDIC Insurance Solutions
California, Illinois, Nevada – 800.733.0633, TDIC Insurance Solutions
Hawaii – 808.521.1841, Jerry Hay, Inc.
Idaho – 208.515.7550, Idaho Dentist Insurance Agency
Minnesota – 800.733.0633, TDIC Insurance Solutions
New Jersey – 877.476.4588, Mid-Atlantic Insurance Resources
Pennsylvania – 877.732.4748, PDAIS, Inc.
Washington- 800.282.9342, Washington Dentists Insurance Agency
All other states – 800.733.0633

FRAUD WARNINGS

General Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Alaska

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Any other terms or conditions of this application and the policy notwithstanding, all statements and descriptions in the application for this policy, or in negotiations therefore, by or on behalf of the insured, shall be deemed to be representations and not warranties.

Arizona

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Any other terms or conditions of the application and this policy notwithstanding, all statements and descriptions in the application for this policy, or in negotiations therefore, by or on behalf of the **insured**, shall be deemed to be representations and not warranties.

The last paragraph under **AUTHORIZATION** is deleted and replaced with "If any **insured** has concealed or misrepresented any material fact or circumstance relating to this insurance at any time, such misrepresentations, omissions, concealment of facts and incorrect

statements shall not prevent a recovery under this policy unless:

1. Fraudulent.
2. Material either to the acceptance of the risk, or to the hazard assumed by the insurer.
3. The insurer in good faith would either not have issued a policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

California

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Hawaii

Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

All statements or descriptions in any application for an insurance policy or in negotiations therefor, by or on behalf of the insured, shall be deemed to be representations and not warranties. A misrepresentation shall not prevent a recovery on the policy unless made with actual intent to deceive or unless it materially affects either the acceptance of the risk or the hazard assumed by the insurer.

Idaho

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada

Any person who knowingly files a statement of claim containing any material misrepresentation or any materially false, materially incomplete or materially misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

Any other terms or conditions of this application and the policy notwithstanding, all statements and descriptions in the application for this policy, or in negotiations therefore, by or on behalf of the insured, shall be deemed to be representations and not warranties.

New Jersey

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

Oregon

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Pennsylvania

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.

Tennessee

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.