Application for Coverage
Workers' Compensation Insurance

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

Please complete this application and fax to 877.686.8349. If you have any questions, please call TDIC at 800.733.0633.

1. **Coverage Effective Date:**__________/__________/__________ **Policy Period** (at 12:01 a.m., standard time)

2. **Contact and Other Professional Information**

Name (Legal Entity Name) __________ Federal Employer ID __________

DBA (if any) __________ ADA# __________

Mailing Address __________

Primary Practice Address __________

Additional Location(s) (provide addresses for all) __________

Name of Primary Office Contact __________ Office Phone No. __________

E-Mail Address __________ Website Address __________ Fax No. __________

3. **Payroll**

Please provide separate information for each office location and indicate any locations outside of California. **Full-time is equal to 30+ hours per week*

Locations State	Class Code	Classification of Principal Operations	No. of Full-Time Employees*	No. of Part-Time Employees	Estimated Annual Payroll
1	8839	Dentist & Dental Surgeons—All Employees			

4. **Workers' Compensation History** (*A claims history, obtained within the last 90 days must be attached)*

Prior Carrier __________ Policy No. __________ Expiration Date __________

Have there been any workers' compensation losses? ☐ Yes ☐ No

If yes, please provide dates and detailed description of the loss(es): __________

Are you purchasing Workers' Compensation due to a practice acquisition ☐ Yes ☐ No

If yes, please provide name of seller: __________

5. **Entity Type**

Type of Business: ☐ Individual/Sole Proprietor ☐ Partnership ☐ Corporation ☐ Joint Venture

☐ Other (specify) __________

Partnership

Partners' Names	Title (Partner, General Partner, Limited Partner)	Duties and Estimated Annual Salary	Partner to be Covered?
			☐ Yes ☐ No
			☐ Yes ☐ No

Application for Coverage
Workers' Compensation Insurance

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

Corporation/Professional Corporation

Officers' Names	Title	% of Stock	Duties and Estimated Annual Salary	Officer to be Covered?
				☐ Yes ☐ No
				☐ Yes ☐ No

Individual/Sole Proprietor (Complete for relatives that work for the practice)

Relatives' Names	Age	Relationship	Duties and Estimated Annual Salary	Residing with the Insured?	Relative to be Covered?
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

These questions must be answered before application is processed. (if any question is answered "Yes", explain in Comments section)

	Question	Yes	No
1.	Do you operate a mobile dental facility?	☐	☐
2.	Do you have any employees working without a valid work permit, if one is required?	☐	☐
3.	Does the employer own, operate or lease any aircraft/watercraft for business purposes?	☐	☐
4.	Has the employer, or its owners or officers, filed for bankruptcy within the last five years?	☐	☐
5.	In the last five years, has the employer had their workers' compensation coverage canceled for non-payment of premium (including with TDIC), had a lapse in coverage or been operating with employees without workers' compensation coverage in force?	☐	☐
6.	Does the employer engage in, or own, any other business other than a dental office?	☐	☐
7.	Do you have and are you currently utilizing a written formal Cal-Osha compliant safety program?	☐	☐
8.	Are you aware of any incident, which could give rise to a claim in the future?	☐	☐
9.	Have you had any employee injuries in the last 5 years?	☐	☐
10.	Years in Business with workers' compensation coverage? (if no prior coverage, indicate zero)	______	
11.	If no prior workers' compensation coverage, on what date did your 1st employee begin work?	______	
12.	Do you employ Leased Employees?	☐	☐
13.	Do you have any remote or telecommuting EEs or ICs? If yes, please indicate, in the comments section, where they are located and nature of controls in place to ensure a safe work environment?	☐	☐
14.	Do you use Independent Contractors as part of your dental practice? (e.g. DA/RDA, other professionals, janitors, scheduling &/or administrative work). If yes, please indicate in the comments section below if Independent Contractor(s) has their own Workers' Comp insurance. If yes, indicate if they have provided proof of this coverage (Certificate of Insurance). If they do not carry their own Workers Comp Insurance (aka, they are uninsured), please include the estimated annual amount for services performed rendered in Question #3 on Page 1 of this application.	☐	☐

Comments Section ____

____

____

____

Application for Coverage
Workers' Compensation Insurance

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

I authorize release and exchange of information between my past and present insurance carriers and The Dentists Insurance Company, involving past and future underwriting and claims matters. I have answered the questions on this application truthfully. I agree to notify The Dentists Insurance Company of any change in the information contained in the application – before and after a policy is issued – and to supply such further underwriting information as The Dentists Insurance Company may require. I further agree to be bound by the underwriting guidelines of The Dentists Insurance Company.

Any insurance issued in response to this application is void if an insured has concealed or misrepresented any material fact or circumstances relating to this insurance at any time prior to issuance or renewal of the policy.

Print Name	Signature	Date
Print Name	Signature	Date