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

Professional Liability Application for New Graduates

THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS, AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant in ink.

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued. Additional information may be required upon review of the application.

Any coverage issued will be issued based on the accuracy of the following information.
All questions must be answered.

Requested Effective Date _____/_____/_____
Referred by: _____

General Information

1. Full Name: _____
   ☐ DDS ☐ DMD ☐ MD ☐ BDS ☐ MS ☐ JD

2. Date of Birth: _____/_____/_____ ☐ Male ☐ Female

3. Practice Address and Percentage of Practice at each Address **(Total % Must Equal 100%)**

   _____
   Street City County State Zip %

   _____
   Street City County State Zip %

   _____
   Street City County State Zip %

4. Mailing Address: _____
   Street City State Zip

5. Telephone Number: (_____)_____ 7. Fax Number: (_____)_____

6. Cell Phone Number: (_____)_____ 8. Email: _____

9. Preferred Contact Method: ☐ Office ☐ Cell ☐ Email ☐ Other: _____

10. Office Manager or Contact Name: _____

11. List any business that you have any financial interest: _____

Preferred billing plan: ☐ Annual ☐ Semi-annual* ☐ Quarterly* ☐ Monthly – EFT only (subject to availability)
**installment fees apply*

Coverage

12. Limits Requested: ☐ $1,000,000 per claim /(aggregate will be indicated on quote)
☐ $2,000,000 per claim / $6,000,000 aggregate ☐ Other: _____

Professional Information

13. Dental School Attended: _____
City State

14. Month/Year of Graduation: _____/_____ Did you complete a residency? ☐ Yes ☐ No
If "Yes" Month/Year Completed _____/_____ Specialty: _____

15. List all active Professional Licenses:

_____|_____
State Type License No. State Type License No.

16. Are you a member of any ***State*** Dental Association/Society? ☐ Yes ☐ No

Please Tell Us About Your Practice

If You Do Not Own the Practice:

17. Under which business structure do you practice?

☐ Employee Dentist Name of Employer/Facility: _____
☐ Independent Contractor Name of Employer/Facility: _____
☐ Faculty Name of Employer/Facility: _____
☐ Volunteer Name of Employer/Facility: _____

If You Own the Practice:

18. Under which business structure do you practice?

☐ Sole Proprietor ☐ Limited Liability Company ☐ Limited Liability Partnership
☐ Incorporated ☐ Partnership
☐ Employee Dentist Name of Employer/Facility: _____
☐ Independent Contractor Name of Employer/Facility: _____
☐ Faculty Name of Employer/Facility: _____
☐ Volunteer Name of Employer/Facility: _____

If you own your practice or operate under a different name:

A. List all entities you own or have ownership in, including dba's and trade names:
_____

B. If you have a legal entity, do you need coverage for the corporation? ☐ Yes ☐ No

C. Is the sole function/purpose of this entity for the practice of dentistry? ☐ Yes ☐ No

D. Do you desire **Shared** or **Separate** limits of liability to apply to your legal entity?
☐ Shared (limits are shared with you at no cost)
☐ Separate (entity has its own set of limits and an additional charge applies)

E. Excluding yourself, name all officers or partners of your legal entity:
_____
_____

F. Please provide the number of the following who work for you:
☐ **Employee dentist** (other than yourself and/or partners/corporate officers)* _____

☐ **Independent contractor dentists* _____**

☐ **Other dentists** sharing facilities with you* _____

***NOTE: For any of the ABOVE, attach proof of professional liability coverage for each.**

☐ **All other employees** (hygienists, assistants, technicians, clerical, etc.) _____

19. Are any of the above leased employees? ☐ Yes ☐ No

20. Do you perform work for any public institutions or federal agencies? ☐ Yes ☐ No
If yes, please provide details in remarks section.

21. Do you practice on behalf of a dental corporation, partnership group or entity?
If yes, please provide details in remarks section. ☐ Yes ☐ No

22. How many hours do you work per week? _____ How many patients do you see and is this required by your employer? _____

Specialty

23. Indicate your Practice Specialty (please check all that apply)

☐ General Dentistry
☐ Endodontics
☐ Oral/Maxillofacial Surgery
☐ Oral Pathology
☐ Full-time Faculty-Non-Intramural
☐ Anesthesiology (Dental) – Conscious Sedation or Minimal Sedation
☐ Dental Radiologist
☐ Oral Radiology
☐ Orthodontics
☐ Pediatric Dentistry
☐ Anesthesiology (Dental) – General Anesthesia
☐ Periodontics
☐ Prosthodontics
☐ Public Health

Procedures Performed in Your Practice

24. Which of the following procedures are performed by you or by someone under your supervision/direction:
    - ☐ Sleep Apnea Therapy If yes, please indicate the following:
      - ☐ I treat only after referral from physician ☐ I treat without physician referral
      - ☐ I fabricate oral appliances for treatment of severe snoring &/or Obstructive Sleep Apnea.
    - ☐ "Sargenti," paste fill or formaldehyde based endodontic techniques **EXCLUDING** formocresol primary tooth pulpotomies.
    - ☐ **IRREVERSIBLE** TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)
    - ☐ Implant Surgery ☐ Extraction of Impacted Teeth ☐ Implant Restoration
    - ☐ Molar Endodontics on Permanent Teeth
    - ☐ NONE OF THE ABOVE

25. Do you treat or prescribe medication for any of the following:
    - ☐ Smoking and/or Tobacco Cessation ☐ Prolotherapy, Platelet Rich Plasma or PRP
    - ☐ Weight Loss Therapy (i.e. wiring of the jaw, etc)

26. Do you offer any spa services? ☐ Yes ☐ No

27. How many referrals do you receive annually? _____
    For what procedures? _____
    Who refers the patients to you? _____
    What procedures do you refer to others? _____

28. Do you obtain a dental/medical history for all patients? ☐ Yes ☐ No

29. How often do you collect an updated health history? _____

30. Do you consistently use informed consent? ☐ Yes ☐ No
    If not consistently, under what circumstances would you use informed consent? _____
    _____

31. Do you consistently use informed refusal of treatment? ☐ Yes ☐ No

32. Do you offer 24 hour emergency care for patients not currently under your care? ☐ Yes ☐ No

33. Do you perform cosmetic dermal procedures (including but not limited to Botox, Restylane, collagen injections, UL Therapy etc.) ☐ Yes ☐ No
    If yes, please provide an explanation in remarks.

34. Does anyone employed by you perform cosmetic dermal procedures? ☐ Yes ☐ No

Anesthetics and Analgesia

35. Are you practicing sleep dentistry? ☐ Yes ☐ No

36. Are you treating patients who are under general anesthesia/deep sedation in your office? ☐ Yes ☐ No

If yes, who administers the anesthesia?
☐ You
☐ Another Dentist or MD Anesthesiologist or CRNA

37. Does the Dentist, MD Anesthesiologist or CRNA carry their own professional liability?
If yes, please provide a copy of their certificate. ☐ Yes ☐ No

Dental Laboratory/Dental Imaging Services

38. Do you operate a dental laboratory? ☐ Yes ☐ No
If yes, do you accept referrals for other than your patients? ☐ Yes ☐ No
If yes, is there a separate business entity/corp for this purpose? ☐ Yes ☐ No

39. Do you utilize any advanced CT imaging scans in your diagnosis and treatment planning? ☐ Yes ☐ No

40. Do you operate any advanced CT imaging equipment? ☐ Yes ☐ No
a. Do you own the equipment? ☐ Yes ☐ No
b. Is the equipment used on patients other than your own? ☐ Yes ☐ No
c. If yes, is there a separate entity/corporation for this purpose? ☐ Yes ☐ No
d. Are the results read by a radiologist? ☐ Yes ☐ No

41. Do you provide radiology services for other than your patients or on a referral basis? ☐ Yes ☐ No

License and Claims History

42. Do you have hospital privileges? ☐ Yes ☐ No
If yes, please provide details in remarks section.

43. Has any governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions? ☐ Yes ☐ No
If yes, provide a copy of the board transcript or other documentation, including resolution.

44. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency? ☐ Yes ☐ No
If yes, provide a copy of the board transcript or other documentation, including resolution.

45. Have you been convicted of any criminal charges? ☐ Yes ☐ No
If yes, please provide details in remarks section.

46. Have you ever been or are you currently being treated for:

Alcoholism	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No
Mental Illness	☐ Yes	☐ No
Physical Impairment	☐ Yes	☐ No

If yes, provide a letter from treating physician with complete details.

47. Are you now, or have you ever, practiced without professional liability insurance?
If yes, please provide details in remarks section. ☐ Yes ☐ No

48. Have you ever had any professional liability insurance refused, cancelled or non-renewed? *If yes, please provide details in remarks section.* ☐ Yes ☐ No

49. Has any claim or suit for alleged malpractice ever been brought against you?
If yes, please provide details in remarks section. ☐ Yes ☐ No

50. Are you currently aware of any situation that could lead to a malpractice suit against you?
If yes, please provide details in remarks section. ☐ Yes ☐ No

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Insurance History

51. Do you have an active Professional Liability policy to cover a practice location for which you are not requesting coverage? *If yes, please provide details in remarks section.* ☐ Yes ☐ No

52. Was an extended reporting endorsement (tail) purchased from your previous carrier? ☐ Yes ☐ No

53. Was your practice during the period for which you are requesting prior acts coverage different in any way from your current practice? *If yes, please provide details in remarks section.* ☐ Yes ☐ No

REMARKS: _____
_____
_____
_____
_____
_____

I, the undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and I have not omitted or withheld any fact or circumstance, which would be relied upon in the determination by the insurance company indicated on this application in granting liability insurance. I understand that this application, and any documents provided are made a part of the policy that is issued. I further understand that any incorrect or incomplete statement could void my protection.

I authorize any state board of examiners or licensers, hospital board or committee, insurance company, professional society, past or present business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to the "Company" or its assigns. I authorize the use of a copy of this acknowledgement in lieu of its original.

I understand that my Professional Liability Coverage will be written on a "Claims-Made form" and acknowledge that this coverage will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" coverage will not provide insurance coverage for claims which occurred prior to the "Prior Acts Date" of my policy.

I understand that, should my "Claims-Made" policy with this "Company" ever be cancelled or non-renewed, for reasons other than non-payment of the premium, or if I decide to terminate the policy for any other reasons, I can elect to purchase any Extended Reporting Period ("Tail") Endorsement subject to the policy terms and conditions. An Extended Reporting Period Endorsement provides protection for any claims which may have occurred during the term of the "Claims-Made" policy, but were not reported to us before the date of the policy termination.

_____

Signature **Date**

_____

Name and title (please print)

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. (For Oregon only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) (For Washington, Idaho and Tennessee residents only: 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.) (For Arizona residents only: 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.)

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

_____

Signature **Date**

For Inquiries:
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