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

Professional Liability Application for Dentists

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 ______/______/______ OR ☐ Renewal
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: ________________________

13. Are you applying for prior acts coverage? ☐ Yes ☐ No
If yes, requested Retroactive Date ______/______/______
Attach a copy of your current declaration page

14. List prior insurance carrier(s) for the past **five (5)** years. If none, state "None"

Insurance Carrier Effective Date Expiration Date Claims-made or Occurrence Limits

____

____

____

15. Are you entering practice for the first time? ☐ Yes ☐ No

Professional Information

16. Dental School Attended: ____
City State

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

18. List all active Professional Licenses:

_____________________________________|_______________________________________
State Type License No. State Type License No.

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

Have you taken a Risk Management Seminar in the last three (3) years? ☐ Yes ☐No
Date of Attendance _____/_____/_____ **Attach your certificate of completion.**

Please Tell Us About Your Practice

If You Do Not Own the Practice:

20. 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:

21. 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.) ___________

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

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

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

25. How many hours do you work per week? _____ How many patients do you see? _____

Specialty

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

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

Procedures Performed in Your Practice

27. 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

28. 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)

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

30. If you are a general Dentist doing specialty procedures:
How many dental referrals do you receive annually? _______________
For what procedures? ____
Who refers the patients to you? ____
What procedures do you refer to others? ____

31. Do all patients complete a written dental/medical history form? ☐ Yes ☐ No

32. How often do your patients complete a written updated health history form? __________________

33. Do you consistently use informed consent? ☐ Yes ☐ No
If not consistently, under what circumstances would you use informed consent? _________________
____

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

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

36. 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.

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

38. Are you offering any new procedures and/ or services? ☐ Yes ☐ No

If yes, please describe: ____

Anesthetics and Analgesia

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

40. 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

41. Does the Dentist, MD Anesthesiologist or CRNA carry their own professional liability insurance?

If yes, please provide a copy of their certificate. ☐ Yes ☐ No

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Dental Laboratory/Dental Imaging Services

42. 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

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

44. 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

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

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License and Claims History

46. Do you have hospital privileges? ☐ Yes ☐ No

If yes, please provide details in remarks section.

47. 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.

48. 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.

49. Have you been convicted of any criminal charges? ☐ Yes ☐ No

If yes, please provide details in remarks section.

50. 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.

51. Are you now, or have you ever, practiced without professional liability insurance?

If yes, please provide details in remarks section. ☐ Yes ☐ No

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

53. Has any claim or suit for alleged malpractice ever been brought against you?

If yes, please provide details in remarks section. ☐ Yes ☐ No

54. 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

55. 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

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

57. 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: ____

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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 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.

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Signature **Date**

Are you interested in receiving a quote on any of the following?

Businessowners Policy	☐ Yes	☐ No
Employment Practices Liability	☐ Yes	☐ No
Workers Compensation	☐ Yes	☐ No
Cyber Liability	☐ Yes	☐ No
ERISA	☐ Yes	☐ No

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