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

Professional Liability Application for Dental Corporations

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 contingent upon the truth of the following information:

☐ New Policy Requested Effective Date _____/_____/_____

☐ Rewrite of Policy Number _____
Referred by: _____

General Information

1. Name of Entity: _____
2. Mailing Address: _____
3. Email Address: _____ 4. Website: _____
5. Telephone Number: (_____)_____ Fax Number: (_____)_____
6. Names of Owner(s)/Partner(s): _____
7. Does the entity own any other business? ☐ Yes ☐ No If yes, please provide information in remarks.

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

Coverage

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

Please Tell Us About the Practice

9. Under which business structure is the practice owned?
   ☐ Sole Proprietor ☐ Limited Liability Company ☐ Limited Liability Partnership
   ☐ Incorporated ☐ Partnership

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

11. Does the entity perform work for any public institutions or federal agencies? ☐ Yes ☐ No

12. Has the entity ever filed for bankruptcy? ☐ Yes ☐ No

13. 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 who are **not** covered under this policy*
   _____

   ***NOTE: For any of the ABOVE 3 selections**, be sure to attach a separate application or proof of professional liability coverage for each.

   ☐ **All other employees** (hygienists, assistants, technicians, clerical, dental anesthesiologists, CRNA's etc.)
   _____

14. Please provide census information for each dentist affiliated with your entity:

Name	**Specialty**	**Insurance Carrier**	**Owner/Partner/ Employee/Contractor**

15. Practice Location(s):

a) _____
Street City County State Zip %

b) _____
Street City County State Zip %

c) _____
Street City County State Zip %

16. Office manager or contact name: _____

Procedures Performed in Your Practice

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

18. Is a dental/medical history obtained for all patients? ☐ Yes ☐ No

19. Is informed consent consistently used? ☐ Yes ☐ No
    If not consistently, under what circumstances would informed consent be used?
    _____

20. Is informed refusal of treatment used? ☐ Yes ☐ No

21. Does the entity offer 24 hour emergency care for patients not currently under your care?
    ☐ Yes ☐ No

Anesthetics and Analgesia

22. Is sleep dentistry practiced? ☐ Yes ☐ No

23. Are patients treated who are under general anesthesia/deep sedation in your office?
    ☐ Yes ☐ No

    If **yes**, who administers the anesthesia?
    ☐ Another Dentist ☐ CRNA
    ☐ Anesthesiologist ☐ Other: _____

Dental Laboratory/Dental Imaging Services

24. Does the entity operate a dental laboratory? ☐ Yes ☐ No
    If yes, are referrals accepted for patients from others not within the practice?
    ☐ Yes ☐ No
    If yes, is there a separate business entity/corporation for this purpose? ☐ Yes ☐ No

25. Are advanced CT imaging scans used in diagnosis and treatment planning? ☐ Yes ☐ No

26. Are radiology services for others provided on a referral basis? ☐ Yes ☐ No

27. Is there any operation of advanced CT imaging equipment? ☐ Yes ☐ No
    a. Is the equipment owned? ☐ 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

License and Claims History

28. License and Claims History:

A. Do you perform background checks including claims history on all employees?
   ☐ Yes ☐ No

B. Do you obtain referrals before hiring new employees? ☐ Yes ☐ No

C. Do you have programs in place addressing the following?

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

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

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

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Insurance History

29. 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 of Liability

_____
_____
_____
_____
_____

30. Are you applying for prior acts coverage? ☐ Yes ☐ No
If yes, please attach a copy of your last declaration page (face sheet).

31. Prior Acts date (Retroactive date) used by your previous carrier _____/_____/_____

32. Is there an active Professional Liability policy to cover a practice location for which coverage is not requested? ☐ Yes ☐ No

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

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

REMARKS: _____
_____
_____
_____
_____
_____

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I hereby authorize The Dentists Insurance Company to release the information on this application and associated underwriting information.

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 insurance carrier ever be cancelled or non-renewed, or I decide to terminate it for any other reasons, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy, but were not reported to the insurance company before the date of the policy termination, I will be able to purchase additional insurance coverage.

FRAUD NOTICE – WHERE APLICABLE 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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