# PracticeProtection Insurance Services
## Dental Professional Liability Application

This is an application for professional liability insurance coverage from PracticeProtection Insurance Services. Please answer all the questions and do not leave any blanks. If a question is not applicable, please write "N/A." In addition to this application, please provide a copy of the Declarations page (face sheet) from your current policy. I agree that any coverage issued by PracticeProtection will be contingent upon the truth of the following information.

**I. PLEASE TELL US ABOUT YOURSELF:**

1. Full Name: _____ ☐ DDS ☐ DMD ☐ MD ☐ BDS
First Middle Last

2. Date of Birth: _____ 3. National Provider Identifier (NPI) Number: _____

4. Dental License #(s): _____

5. Mailing Address: _____
Street City State Zip Code

6. Office Number: (_____) _____-_____ 7. Cell Number: (_____) _____-_____

8. Email address: _____ 9. Website address: _____

10. Have you ever failed any portion of the Dental Board Exam more than three times? ☐ Yes ☐ No

11. How did you hear about PracticeProtection? _____

**II. PLEASE TELL US ABOUT YOUR REQUESTED PROFESSIONAL LIABILITY INSURANCE COVERAGE:**

12. Requested Effective Date: _____ 13. Requested type of coverage: ☐ Claims Made ☐ Occurrence

14. Requested Limits: ☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000 ☐ $400,000/$1,200,000
☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000 ☐ Other $_____

**III. PLEASE TELL US ABOUR YOUR PRACTICE:**

15. Practice Affiliation: ☐ Owner ☐ Employee ☐ Independent Contractor

16. Please provide the number of Allied Health Personnel working in your office:

____ Dental assistants ____ Dental hygienists ____ Dental therapists ____ Other: _____

17. Do you practice on behalf of a dental corporation, partnership, or other entity? ☐ Yes ☐ No

If yes, please complete the following:
a. Legal name of entity: _____
b. Doing Business As (DBA) name(s): _____
c. Please indicate which coverage is desired for your entity(s) named above?
☐ Shared Limits (no additional cost)
☐ Separate Limits (an Entity Supplement Form will be needed)

18. Practice Addresses and Percentage of Practice at Each Address (Total of Percentages Must Equal 100%):

a. _____
Street City County State Zip Code %

b. _____
Street City County State Zip Code %

c. _____
Street City County State Zip Code %

19. Please indicate your average number of practice hours per week that will be covered by this policy including office hours, administrative activities, direct patient care, surgery, consultation, etc. (excluding on-call}: _____

**IV. PLEASE TELL US ABOUT YOUR SPECIALTY AND PROCEDURES:**

20. Indicate your Practice Specialty (Please check all that apply)

| | | | |
|---|---|---|---|
| ☐ General Dentistry | ☐ Endodontics | ☐ Pediatric Dentistry | ☐ Orthodontics |
| ☐ Dentofacial Orthopedics | ☐ Dental Public Health | ☐ Oral Pathology | ☐ Periodontics |
| ☐ Oral/Maxillofacial Radiology | ☐ Prosthodontics | ☐ Dental Anesthesiology | ☐ Oral/Maxillofacial Surgery |
| ☐ Dental Assistant | ☐ Dental Hygienist | ☐ Dental Therapist | ☐ Other _____ |

21. Indicate which of the following procedures you perform (Select at least one)

- ☐ None of the following
- ☐ Surgical placement of implants — If so, please indicate what percentage of your practice it is: _____%
- ☐ Extractions of partially impacted teeth — If so, please indicate what percentage of your practice it is: _____%
- ☐ Extractions of fully impacted teeth — If so, please indicate what percentage of your practice it is: _____%
- ☐ Sleep apnea therapy — If so, please indicate what percentage of your practice it is: _____%
- ☐ Cosmetic dermal procedures — If so, please indicate what percentage of your practice it is: _____%
- ☐ Other procedure(s) not normally in specialty - If so, what procedure(s): _____
  and please indicate what percentage of your practice the Other procedure(s) is(are): _____%

22. Under which of the following types of sedation/anesthesia do you treat patients (Select at least one)

☐ None of the following ☐ IV/IM (Moderate Sedation) ☐ General Anesthesia (Deep Sedation)

23. Do you administer sedation/anesthesia to patients other than your own? ☐ Yes ☐ No

24. Do you administer General Anesthesia/Deep Sedation? ☐ Yes ☐ No

**V. <u>PLEASE TELL US ABOUT YOUR LICENSE AND EXPERIENCE:</u>** (If the answer is Yes to any of the questions in the Section, please provide an explanation in Section VII. ADDITIONAL REMARKS.)

25. **LICENSURE ACTIONS**: Have you ever had any of the following denied, revoked, suspended, placed on probation, subject to reprimand, voluntarily surrendered, limited in any manner or is it currently under investigation:

- a. your license to practice dentistry? ☐ Yes ☐ No
- b. your DEA or State permit to dispense or prescribe drugs? ☐ Yes ☐ No
- c. your privileges with a hospital, managed care organizations or other healthcare facility? ☐ Yes ☐ No

26. **INSURANCE ACTIONS**: Have you ever had any professional liability insurance cancelled, declined, refused, or non-renewed? ☐ Yes ☐ No

27. **CRIMINAL ACTIONS**: Have you ever been charged with or convicted of a felony or misdemeanor (other than a minor traffic violation)? ☐ Yes ☐ No

28. **MENTAL HEALTH/SUBSTANCE ABUSE**: Are you or have you ever been evaluated for, diagnosed with, treated for, or hospitalized for: alcohol, narcotics, any other substance abuse (or central nervous system stimulants or depressants), sexual addiction, mental or emotional illness? ☐ Yes ☐ No

29. **CHRONIC IMPAIRMENT**: Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? ☐ Yes ☐ No

**VI. <u>PLEASE TELL US ABOUT YOUR CLAIMS HISTORY:</u>** (If the answer is Yes to any of the questions in the Section, please complete a Claim Supplement Form for each event and provide any additional explanation in Section VII. ADDITIONAL REMARKS.)

30. **PRIOR MALPRACTICE CLAIMS**: Are you currently involved in or have you ever been involved in a malpractice claim or suit including any expression of intent by a third party (i.e. records request, incident reports, or notices of intent) even if a suit was never filed? ☐ Yes ☐ No

31. **PRIOR POTENTIAL CLAIMS/INCIDENTS**: Do you know of or is it reasonably foreseeable from the facts or circumstances regarding any procedure, treatment or diagnosis you have performed or made in the past that might reasonably lead to a claim or suit being brought against you? ☐ Yes ☐ No

32. **UNREPORTED CLAIMS/INCIDENTS**: Are there outstanding incidents, claims or suits, or potential incidents, claims or suits, regardless of merit, pending against you? ☐ Yes ☐ No

33. **REGULATORY ACTIONS**: Have you been notified to respond to, appear before or been investigated by any regulatory agency and/or state dental board on a complaint of any nature? ☐ Yes ☐ No

**VII. <u>ADDITIONAL REMARKS:</u>** Please use the space below to provide any further explanation to any of the previous responses. Please also include any additional information or attach documentation as needed to best inform PracticeProtection of anything that would be useful in the underwriting of your application for insurance. (i.e. common procedures/diagnoses, specialized trainings, CME coursework, Risk Management tools/programs, etc.) If additional space is needed, please attach a separate page.

_____

_____

**VII. ADDITIONAL REMARKS (continued):**

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## Acknowledgement, Authorization and Agreement

I hereby acknowledge that the foregoing information and all supplemental and supporting documentation and other information that I provide constitutes my application for insurance with PracticeProtection Insurance Services and that all information requested in this application is considered material and important. I hereby declare that all answers and statements herein given are true and complete based upon my personal knowledge of what is reasonably foreseeable from the facts, reasonable inferences or circumstances applicable to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgement of PracticeProtection in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations and, if PracticeProtection agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application. I understand that no insurance will be afforded unless and until this application is accepted by PracticeProtection and I am notified of said acceptance.

If you asked us to provide coverage for Prior Acts coverage for your professional liability exposure, you must inform all prior carriers of any claims, suits, incidents or circumstances that might lead to a claim being made against you. I hereby certify that as of the date of this application, all known incidents, claims or suits, and all circumstances and potential incidents, claims or suits have been reported to my current insurance carrier and/or applicable prior insurance carriers. I understand that my PracticeProtection policy, if offered, will not provide coverage for these incidents, regardless of whether I have reported them to my prior insurance carriers.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualification, which involves either underwriting of clams matters, may be conducted by PracticeProtection. I consent to any investigations or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceeding, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physicians Resource Network, individuals and PracticeProtection. I expressly release and discharge the aforesaid entities, their agents, Employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I understand that, if I am insured by PracticeProtection, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for as long as I maintain a business relationship with, and any party furnishing information pursuant to the authorization is entitled to rely on the representation of PracticeProtection that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to PracticeProtection.

Signature _____ Printed Name _____ Date _____

(A photostat copy of this authorization shall be considered as effective and as valid as the original)

Notice regarding Claims Made Coverage: Except to such extent as may otherwise be provided in the Policy and its endorsements, the coverage of the Policy is limited generally to liability only for those claims that are first reported in writing to the Company while the Policy is in force. Please review the Policy carefully and discuss the coverage with your legal advisor.

Notice: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.