DOCTORS professional liability

Dental Professional Policy Application

NOTICE TO APPLICANTS FOR DENTAL PROFESSIONAL LIABILITY ON A CLAIMS MADE BASIS:

The dental professional liability coverage applied for is limited generally to liability for only those claims which arise from dental incidents taking place on or after the retroactive date of the policy and which are first made against the Insured and reported to the Company in writing during the policy period or any applicable reporting period. Please discuss with your insurance agent or broker.

GENERAL INFORMATION

Please type or print. EVERY ITEM MUST BE COMPLETED. If not applicable, write N/A. If additional space is required, please provide your answers on a copy of your practice letterhead.

1. _____ _____ _____ 1A. _____
   FIRST NAME MI LAST NAME BIRTHDATE
2. _____ 2A. _____
   NAME OF PRACTICE NAME OF PRIMARY CONTACT / FIRST & LAST
3. PRIMARY MAILING ADDRESS
   _____ _____ _____ _____ _____
   STREET CITY COUNTY STATE ZIP
4. PRIMARY OFFICE LOCATION / ADDRESS
   _____ _____ _____ _____ _____
   STREET CITY COUNTY STATE ZIP
5. ADDITIONAL PRACTICE LOCATION
   _____ _____ _____ _____ _____
   STREET CITY COUNTY STATE ZIP

CONTACT INFORMATION

6. _____ _____ _____
   BUSINESS PHONE RESIDENCE PHONE NUMBER EMAIL ADDRESS
7. _____ _____ _____
   FAX NUMBER CELL PHONE NUMBER WEB PAGE URL

COVERAGE INFORMATION

1. When did you start private practice? ___ / ___ / ___ (MM DD YY) 2. Requested Policy Effective Date ___ / ___ / ___ (MM DD YY)
3. ☐ Claims made Coverage 3a. If claims made coverage, please include a copy of your current declarations page AND provide retroactive date: ___ / ___ / ___ (MM DD YY)

DENTAL PROFESSIONAL LIABILITY LIMITS

A. ☐ $1,000,000/$3,000,000 B. ☐ $200,000/$600,000 C. ☐ $250,000/$750,000
D. ☐ $500,000/$1,500,000 E. ☐ $1000,000/$3000,000 F. ☐ $1,300,000/$3,900,000 (New York Only)

23276 S. Pointe Dr. Suite 204 Laguna Hills , California 92653 * P 888-959-9456 * F 888-600-6280 * W www.DPLRRG.com

Current Insurer: _____ Limits of Liability: _____ Annual Premium: _____

In which state(s) are you licensed to practice and what percentage of time do you practice there?

STATE	LICENSE #	% OF PRACTICE	STATE	LICENSE #	% OF PRACTICE

EDUCATION

1. Are you a General Dentist? ☐ Yes ☐ No

2. If limiting your practice to a specialty, are you licensed in that specialty? ☐ Yes ☐ No

3. What is your specialty? ☐ Yes ☐ No

☐ Periodontist ☐ Prosthodontist ☐ Endodontist ☐ Pediatric Dentist ☐ Orthodontist
☐ Oral Pathologist ☐ Oral Surgeon ☐ Public Health Dentist ☐ Oral Radiologist

4. Are you a member of any dental organization(s)? ☐ Yes ☐ No

If "yes" please provide the name(s) of the organization(s): _____

_____

5. List your training and education. (If more space is required, use a sheet of practice letterhead).

DENTAL SCHOOL / DEGREE	DATE COMPLETED	CITY	STATE	COUNTRY	PROGRAM

RESIDENCY LOCATION	DATE COMPLETED

POST GRADUATE CERTIFICATION – CV/CE LISTING

SPECIALTY
SPECIALTY LICENSE (IF APPLICABLE) DATE COMPLETED

PLEASE ENCLOSE A CURRENT COPY OF CV IF APPLICABLE

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6. Board certification: In what area(s) if any are you Board Certified of Eligible?

   A. BOARD CERTIFIED: _____

   Date: _____ ☐ N/A

   B. BOARD CERTIFIED: _____

   Date: _____ ☐ N/A

7. DRUG LICENSE: _____ DEA NUMBER: _____

8. Anesthesia Permit #: _____

9. Have you participated in a risk management program within the last 3 years? ☐ Yes ☐ No
   If No, would you like additional risk management information? ☐ Yes ☐ No

10. Please describe current certification in cardiac life support and other emergency medical care and indicate expiration date of last certificate:

    _____

    _____

    _____

    Date: ____ / ____ / ____
    MM DD YY

YOUR PRACTICE

1. Do you own your practice? ☐ Yes ☐ No
   If yes, please attach a copy of your practice letterhead, If No, skip to Question 2.
   A. Name of Business: _____
   B. IRS Number: _____
   C. Corporate NPI Number _____
   D. Are you incorporated? ☐ Yes ☐ No
      If yes, date of incorporation? _____ (MM/DD/YY)
   E. Do you or your corporation employ other dentist(s)? ☐ Yes ☐ No
      If yes, how many dentists in practice? _____
      Also, if Yes, please provide a copy of the current Certificate of Insurance for each employed Dentist.
   F. Are other dentists working under a written contract with you and/or your corporation to provide services? ☐ Yes ☐ No
      If Yes, please provide a copy of the current professional liability declarations page for each dentist under contract.
   G. Are other non-employed dentists working with your or your corporation without a written contract? ☐ Yes ☐ No
   H. Do you share, lease or own office space with another dentist? ☐ Yes ☐ No
   I. Is your practice a partnership? ☐ Yes ☐ No

J. How many dental units does your office have? _____

K. Do you employ or contract any dental auxiliary or other office staff? ☐ Yes ☐ No

If Yes, please provide the number of each employed:

Dental Assistants _____ Nurse Anesthetists _____ Dental Hygienists _____

Lab Technicians _____ Other Office Staff _____

2. A. Are you a salaried employee of another dentist? ☐ Yes ☐ No

B. Are you providing services under contract to another dentist? ☐ Yes ☐ No

C. Are you associated with another dentist? ☐ Yes ☐ No

3. Do you have a physician or surgeon in your practice? ☐ Yes ☐ No

If yes, please explain: _____

BASED UPON YOUR ANSWERS TO QUESTIONS 4 THROUGH 10 BELOW, COMPLETION OF A SUPPLEMENTAL APPLICATION MAY BE REQUIRED.

4. Please provide the percentages of your practice which fall into the following CDT codes (must total 100%):

DENTAL PROCEDURE	%
Diagnostic	
Preventive	
Restorative	
Endodontics	
Periodontics	
Prosthodontics (Removable)	
Maxillofacial Prosthetics	
Implant Services	
Prosthodontics (Fixed)	
Oral and Maxillofacial Surgery	
Orthodontics	
Adjunctive General Services	

5. Please confirm if you currently perform any of the following dental techniques or procedures:
   A. Sargenti, RC-2B, N2 ☐ Yes ☐ No
   B. Radiation therapy ☐ Yes ☐ No
6. Laser (Excluding curing composites and whitening) ☐ Yes ☐ No
7. Botox injections (other than treating facial spasms, TMJ pain dysfunction and muscular pain) ☐ Yes ☐ No
8. How many complex cases do you perform each year in which the fees total more than $20,000? ☐ Yes ☐ No
9. Do you do full mouth reconstructions? (affecting more than 90% of the teeth in the mouth) ☐ Yes ☐ No
   If "yes," how many do you perform each year? _____

Please indicate below if you perform any surgical procedures. If "yes," please estimate the percentage each surgical procedure bears to your total practice (based on numbers of procedures) on an annual basis.

PROCEDURE	NUMBER OF PROCEDURES
Advanced Implants	
Implants	
Extractions of bony impacted, or partially bony impacted teeth	
Other dental cosmetic procedures (excluding biopsies, but including TMJ)	
Other surgery, including non-dental procedures (describe):	

OFFICE PROCEDURES

1. Please confirm the average number of patients you see per week _____, and average number of practice hours you work per week _____.
   If you are working less than 20 hours per week you may qualify for a part-time discount. Please explain the following: a.) the reason for your part-time status, and b.) who will handle emergencies when you are out of the office?
   _____
   _____
   _____
   _____

2. What is your patient mix? Adults _____ Children _____

INFORMED CONSENT

3. What type of Informed consent do you use? ☐ Oral ☐ Written ☐ None
   If oral, is chart noted, dated and initiated by patient? ☐ Yes ☐ No ☐ Not applicable
4. If Informed Consent is written is it witnessed? ☐ Yes ☐ No
   Please provide a sample copy of your Informed Consent Form.
5. Is Informed Consent obtained at the start of each procedure? ☐ Yes ☐ No
6. Do you obtain a complete patient medical history? ☐ Yes ☐ No
7. How often do you or your staff update patient histories? ☐ Each Visit ☐ Occasionally ☐ No Policy
   If occasionally, what is your procedure? _____

ANESTHETICS AND ANALGESIA

Please describe your use of anesthetics and types of analgesia in your practice as indicated below. For purposes of this application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.

1. Do you use conscience sedation?Do you use conscience sedation?	☐ Yes ☐ No
2. Is oral conscious sedation used?	☐ Yes ☐ No
3. Is IV, IM or sub-cutaneous conscious sedation used? If yes, are you administering the sedation and performing the dental procedure?	☐ Yes ☐ No ☐ Not Applicable
4. Are you treating patients who are under general anesthesia (deep sedation)?	☐ Yes ☐ No
If yes, are you administering the anesthesia and performing the dental procedure?	☐ Yes ☐ No ☐ Not Applicable
5. If you answered "Yes" to any of the questions 1 – 4 above: Are the procedures performed in a dental office?	☐ Yes ☐ No

6. If you answered number 5 above "Yes," please indicate below or on your letterhead (if necessary) the type of agents used for each "Yes" answer, the frequency of use and by whom (yourself, MD Anesthetist, RN Anesthetist or other) the anesthesia is administered.

AGENTS	FREQUENCY	ADMINISTERED BY
AGENTS	FREQUENCY	ADMINISTERED BY

OTHER EXPOSURE INFORMATION

1. Do you own or operate a dental laboratory? If Yes, please estimate percentage of work applicable to your own patients _____%	☐ Yes ☐ No
2. Do you own or operate any other business enterprise, either in conjunction with your practice or not? (e.g. spa services, consulting services, etc.) If Yes, please describe: _____ _____	☐ Yes ☐ No
3. Have you signed any contractual agreements where you have agreed to provide services to others? Please identify parties to the contract and describe services: _____ _____	☐ Yes ☐ No

CLAIMS AND EXPERIENCE INFORMATION (FOR THE PAST 10 YEARS)

If you answer "Yes" to questions 1, 2 or 3 below, please provide on your letterhead the information requested below for each claim.

A. Claimant's Name
B. Date of Alleged Error
C. Name of Insurer
D. If claim is closed, the total amount paid
E. If claim is pending, the claimant's demand amount and the insurer's loss reserve,
F. Description of claim including alleged error according to the claimant and your description of your treatment and extent of injury sustained.

1. Has any claim been made against you alleging dental malpractice?	☐ Yes ☐ No
2. Do you know of any facts, circumstances, injuries, damages, acts, errors or omissions which may result in a malpractice claim against you, other dentists employed by you or your auxiliary staff?	☐ Yes ☐ No
If "Yes", have these been reported to a professional liability insurer?	☐ Yes ☐ No
3. Have you ever utilized Peer Review in an attempt to settle a patient dispute?	☐ Yes ☐ No
4. Please answer the following. For any "Yes" answers, please explain on your letterhead.	☐ Yes ☐ No
a. Have you ever had any restriction, suspension, probation or revocation of a license to practice dentistry? If yes, please explain: _____ _____	☐ Yes ☐ No

b. Have you ever had any restriction, suspension, probation or revocation of a license to administer or prescribe drugs? If yes, please explain: _____ _____	☐ Yes ☐ No
c. Have you ever had any restriction, suspension, probation or revocation of privileges in any hospital or other health care facility? If yes, please explain: _____ _____	☐ Yes ☐ No
d. Have you ever had any personal health problems (including alcoholism, drug addiction, mental illness or communicable disease)? If yes, please explain: _____ _____	☐ Yes ☐ No
e. Have you ever had complaints filed against you involving the administration of Medicare/Medicaid or patient insurance? If yes, please explain: _____ _____	☐ Yes ☐ No
f. Other than traffic violations, have you ever been convicted of a crime? If yes, please explain: _____ _____	☐ Yes ☐ No
g. Have you ever been declined or cancelled for any Dental Professional Liability Insurance? (Missouri residents: Do not answer) If yes, please explain: _____ _____	☐ Yes ☐ No
h. Allegations of sexual harassment, unfair discrimination or other wrongful employment practices? If yes, please explain: _____ _____	☐ Yes ☐ No

NOTICE TO APPLICANT: PLEASE READ CAREFULLY

CLAIMS MADE POLICIES ONLY: I understand that my Dentist's Liability coverage is 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 Retroactive Date of my policy.

I understand that, should my "Claims-made" policy with this insurance carrier ever be cancelled or nonrenewed, or I decide to terminate it for any 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 have sixty (60) days in which to purchase a Reporting Endorsement. Such Reporting Endorsement is required to provide coverage for claims reported to the insurance company after the termination date, but which are based on dentistry performed during the active policy period.

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

FRAUD WARNING NOTICE

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 information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FAIR CREDIT REPORTING ACT

This notice is given to comply with the Fair Credit Reporting Act (Public Law 91-509) and any similar state law which is applicable. As part of our underwriting procedure, a routine inquiry may be made which will provide information concerning character, general reputation, personal characteristics and mode of living.

I understand any policy issued will rely on the truth of the statements and representations I have made herein and that false or misleading statements or misstatement or misrepresentations may result in a denial of coverage for any claim which may be made under the insurance for which application is made hereunder.

I hereby authorize and direct any person or organization to release and furnish to the Insurance Company/Risk Retention Group any and all information requested which may relate to my insurability under the Professional Liability Policy.

_____ _____

APPLICANT'S SIGNATURE DATE

Application is made to Doctors Professional Liability, RRG.

This program is only available within the United States. Coverages, rates and limits differ in some states. Availability of this program is subject to each state's approval.

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