Equity Partners Insurance Services, Inc	**Allied Medical - Healthcare Division**	**Application for Professional Liability Insurance for Dentists (Claims-Made Form)** **EMAIL:** submissions@epinsurance.com **WEBSITE:** www.epinsurance.com/alliedmedical-healthcare/

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR DENTISTS

The following documentation must be submitted with the fully completed application:

- **Copy of your current policy declarations page. (Claims-made policies must reflect retroactive date.)**
- **Copy of all licenses and certifications.**
- **Copy of all prior reporting endorsements issued to you.**
- **Currently valued 7-year claims/loss history from prior companies.**
- **Copy of your business letterhead.**
- **Copy of all advertising that you use.**
- **Copy of your curriculum vitae.**

NOTE: Submission of a completed application confers no obligation upon the company to bind coverage.

(If more space is needed to answer any question, use page 7or a separate sheet.)

1. A. Name of Applicant_____Degree_____
   First Middle Last

   B. Principal Practice Address:_____
   Street County

   _____
   City State Zip

   C. Phone:_____ D. Fax:_____

   E. E-Mail Address:_____ F. Website Address:_____

   G. Secondary Practice Locations_____

   _____

   H. Social Security No._____ I. Date of Birth: _____

2. Are you a U.S. Citizen? ☐ YES ☐ NO
   If no, please indicate your status and date of entry into USA on page 8.

3. Provide the following information for all of the states in which you practice:

State	% of Practice	License No.	Effective Date	Expiration Date	Active (Yes/No)

4. Federal DEA License Number and Status: _____

5. Dental School : _____

   A. Date Graduated: _____

   B. Additional Specialty Training: _____

   C. Board Certifications and Dates: _____

6. Have you participated in continuing education within the past five years? ☐ Yes ☐ No

   If yes, please attach details.

7. A. Do you have a degree which enables you to practice in another field, such as law or medicine?

   ☐ Yes ☐ No

   If yes, please describe:_____

   B. Do you practice in this field? ☐Yes ☐ No

   If yes, are you insured for this exposure? ☐ Yes ☐ No

8. Character of Practice (check all that apply):

   ☐ General Dentistry ☐ Periodontics

   ☐ Endodontics ☐ Prosthodontics

   ☐ Oral/Maxillofacial Surgery ☐ Full-Time Faculty

   ☐ Anesthesiology (Dental)-General Anesthesia ☐ Pediatric Dentistry

   ☐ Anesthesiology (Dental)-Conscious Sedation ☐ Orthodontics

   ☐ Oral Pathology ☐ Multi Specialty (indicate specialties)_____

9. Do you perform the following procedures in your practice?

   Periodontal surgery ☐ Yes ☐ No

   Crown and fixed bridge work with change in vertical dimension (other than to restore to normal pre-existing position) ☐ Yes ☐ No

   Multi-rooted or canaled endodontics ☐ Yes ☐ No

   Surgical extractions other than simple extractions ☐ Yes ☐ No

   Comprehensive orthodontics on adults ☐ Yes ☐ No

   Comprehensive orthodontics on children 18 or younger ☐ Yes ☐ No

   Placement of surgical implants ☐ Yes ☐ No

   If yes, what type of implants and who is the manufacturer? _____

   Assist in orthognathic surgery ☐ Yes ☐ No

   Observe in operation room during orthognathic surgery ☐ Yes ☐ No

   Comprehensive TMJ ☐ Yes ☐ No

Sargenti Technique ☐ Yes ☐ No

Cosmetic plastic surgery (Rhinoplasty, Otoplasty), etc.) ☐ Yes ☐ No

Surgical jaw reduction ☐ Yes ☐ No

10. A. Type of Practice: ☐ solo practitioner (unincorporated) ☐ solo practitioner (incorporated)*

☐ professional corporation* ☐ professional association*

☐ limited liability company* ☐ partnership*

☐ employee of _____

☐ independent contractor of _____

☐ other_____

* Specify name of entity:_____

B. Do you want coverage for the entity named in Item 10.A. above? ☐ Yes ☐ No

C. If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all dentists or oral surgeons practicing under the entity named in Item 10.A. above.

_____

_____

D. Do you practice with any dentist or oral surgeon not named in Item 10.C. above? ☐ Yes ☐ No

If yes, provide the name of each dentist and the practice relationship.

_____

_____

E. Do you employ, contract with or supervise any dentists or oral surgeons? ☐ Yes ☐ No

If yes, provide number and attach current certificate(s) of insurance. Number: _____

F. Do you have any office or expense sharing arrangements with any other dentists or oral surgeons other than those named in 10.C. or D. above? ☐ Yes ☐ No

If yes, provide number and attach current certificates(s) of insurance for the other dentists or oral surgeons. No. _____

G. Do you **E**mploy, **C**ontract with or **S**upervise any dental care extenders? ☐ Yes ☐ No

If yes, enter how many below:

	E	**C**	**S**
Certified Dental Assistants			
Non-Certified Dental Assistants			
Dental Hygienists			
Nurse Anesthetists			
Anesthesiologists			
Other Professionals			

11. Do the employees and/or contractors carry their own professional liability insurance? ☐ Yes ☐ No
    If yes, provide a copy of their Certificates of Insurance.
12. How long have you been practicing your current professional occupation: _____ years
13. List all locations and dates where you have practiced in the last ten (10) years.

Practice Name	City/State	Specialty Practiced	From	To

14. Provide the following information for all hospitals and surgicenters where you are currently on staff:

Name	City	State	Percentage of Work	Type of Privileges

15. A. What is the average number of patients treated by your total practice per day? _____
    B. What is the average number of patients *you t*reat per day? _____
    C. What is the total number of hours you work per week? _____
16. Complete the following:
    A. Do you utilize local anesthesia? ☐ Yes ☐ No Number per year _____
    B. Do you utilize inhalation sedation? ☐ Yes ☐ No Number per year: _____
    C. Do you utilize intravenous or intramuscular sedation? ☐ Yes ☐ No
    D. Do you utilize general anesthesia? ☐ Yes ☐ No
    E. Do you obtain a complete medical history on all patients? ☐ Yes ☐ No
    If yes, how often is it updated? _____
    (ATTACH A COPY OF THE MEDICAL HISTORY FORM USED IN YOUR PRACTICE)
17. Check those items which accurately describe your practice characteristics:
    ☐ I am currently CPR certified.
    ☐ At least one other staff member in my office is currently CPR certified.
    ☐ I have taken ACLS training.
18. I maintain and am trained to use the following items in my office in case of a medical emergency:
    ☐ Oral Airway ☐ Ambu Bag ☐ Endotracheal Tubes/Scope
    ☐ Oxygen ☐ Emergency Drugs
19. A. Do you work for any locum tenens companies as an ☐ employee or ☐ independent contractor?
    ☐ Yes ☐ No

B. Number of hours each month in which you work in locum positions: _____

C. Does each company provide you with Professional Liability Insurance for locum positions?

☐ Yes ☐ No

If yes, attach a copy of your Certificate(s) of Insurance.

20. Do you now or have you ever provided services to any state, local or federal correctional facility, jail or prison? ☐ Yes ☐ No
If yes, please explain: _____

21. Have there been any changes in your specialty or practice activities within the past ten (10) years?

☐ Yes ☐ No

If yes, describe the changes: _____

22. Do you anticipate any changes in your specialty or practice activities in the next year?

☐ Yes ☐ No

If yes, describe anticipated changes: _____

23. Do you perform any procedures not routinely performed by other persons practicing your specialty?

☐ Yes ☐ No

If yes, please provide complete details_____

If you answer "yes" to questions 24 through 30, please provide details on page 8.

24. Has any licensing authority or hospital ever reprimanded you or ever denied, revoked, suspended, or restricted your dental license, narcotics license or practice privileges or put you on probation? ☐ Yes ☐ No

25. Has any licensing authority or hospital conducted or are they currently conducting an investigation relating to the nature of your practice privileges, or to the restriction or limitation of your license or privileges? ☐ Yes ☐ No

26. Have you ever been indicted, charged, arrested (other than for motor vehicle violations) or convicted of any offense, crime or misdemeanor in any state or any federal jurisdiction? ☐ Yes ☐ No

27. Have you ever been evaluated, diagnosed, or treated for any disease or mental, physical or emotional condition, including without limitation, chemical or alcohol dependency? ☐ Yes ☐ No

28. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

29. Do you have a physical handicap or any chronic disease? ☐ Yes ☐ No

30. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors, or public health insurance payors, including but not limited to, Medicare or Medicaid? ☐ Yes ☐ No

31. A. Provide details of Professional Liability coverage for the past five (5) years, including moonlighting positions:

Company Name	Each Claim Limit	Aggregate Limit	Policy Dates From To	Claims Made or Occurrence?	Retroactive Date

B. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? ☐ Yes ☐ No

If yes, provide explanation on supplemental sheet.

C. Have you ever been without professional liability coverage since beginning practice?

☐ Yes ☐ No

If yes, provide explanation on supplemental sheet.

D. Do you have professional liability insurance for work you do elsewhere? ☐ Yes ☐ No

If yes, provide explanation on supplemental sheet.

E. If prior coverage is Claims-Made, has a Reporting Endorsement ("tail" coverage) been purchased? ☐ Yes ☐ No

If no, provide explanation on supplemental sheet.

IMPORTANT INFORMATION REGARDING QUESTIONS 32A AND 32B (INCLUDING SUB-QUESTIONS)

1. The word "claim" as used in questions 32A and 32B as follows refers to:

   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional services and brought against you or any partner, associate, employee, or professional corporation or partnership; or

   b. Circumstances which have been brought to your attention by a patient or legal representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.

2. If you answer yes to any parts of questions 32A and 32B, please complete the Supplementary Claims Information Form on page 10 for all such claims.

32. A. Have you ever been involved in a malpractice claim or suit, either directly or indirectly?

☐ Yes ☐ No

If yes, how many? _____ (Provide details for each on page 10.)

B. Other than the claims/suits indicated in 32.A., are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

1. A request for records from a patient and/or attorney related to an adverse outcome?

☐ Yes ☐ No

2. A letter from an attorney regarding your dental treatment of a patient?

☐ Yes ☐ No

3. Patient or family members dissatisfied with the outcome of a procedure, treatment or diagnosis? ☐ Yes ☐ No

4. Knowledge or information relating to service or services on a Board which might result in a claim? ☐ Yes ☐ No

5. Any other circumstances that might reasonably lead to a claim or suit?

☐ Yes ☐ No

6. Have all circumstances that might reasonable lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability company? ☐ Yes ☐ No

   a. If yes, how many? _____ (Provide documentation of all such reports.)

   b. If no, please provide details on page 8.

7. Has any prior professional liability company refused coverage for, or declined to accept a report of a dental incident, threat of claim, letter of intent, adverse result notice or attorney contact? ☐ Yes ☐ No

   If yes, provide explanation on page 8.

33. Effective Date Desired:_____ Retroactive Date Desired:_____

   (*NOTE: THE COMPANY MAY NOT PROVIDE DESIRED DATES.)*

34. Policy Limits Desired (each occurrence/aggregate): ☐$100,000/$300,000 ☐ 200,000/$600,000 ☐$250,000/$750,000 ☐$1,000,000/$3,000,000 ☐ Other:_____

SUPPLEMENTAL INFORMATION

Please use this form to provide additional information or to answer any questions.

Question No.	

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or “CLAIMS MADE AND REPORTED” basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an “OCCURRENCE” basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In New York: 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 and 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.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Equity Partners Insurance Services and its respective Insurance Company[s] it is working with.

Signature of Applicant	Date

SUPPLEMENTAL CLAIM INFORMATION

If reporting more than one claim, please photocopy this form, and complete a separate form for each claim.

If space is insufficient to answer any question fully, please attach a separate sheet. All questions must be answered or marked not applicable (N/A).

1. Patient's Name:_____

   Date reported to insurance company:_____
2. Name of insurance company:_____
3. Date of incident and your treatment:_____

   _____
4. Allegations:_____

   _____

   _____
5. What is the present condition of the patient? _____

   _____
6. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ☐ Yes ☐ No
7. Status of claim (check applicable answer):

☐ Suit threatened, no action taken	Court outcome in your favor:	Unresolved/Open Claim:
☐ Suit filed but dropped by claimant	☐ Jury verdict	☐ Awaiting mediation
☐ Summary judgment in your favor	☐ Directed verdict	☐ Awaiting court action
☐ Suit settled out of court	Court outcome in favor of plaintiff:	Reserve Amount:
a. Date claim paid:_____	☐ Jury verdict	$_____
b. Amount paid: $ _____	☐ Directed verdict	
c. Did you want to settle this claim? ☐ Yes ☐ No	Amount of loss payment: $ _____	

8. Name and address of the attorney assigned to your case:_____
9. To your knowledge, was any settlement paid by another party involved (your P.A., P.C., partners, employees, etc.)? ☐Yes ☐ No

   If yes, what was the amount of the settlement? _____
10. Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:_____

    _____

    _____

    _____