Dental Professional Liability Insurance—Claims-Made Dentist Application

ProAssurance Indemnity Company, Inc. • PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • 205.877.4400 • Fax 205.868.4040

With your fully completed, signed and dated application, you must submit the following information:

1. Current insurance policy declarations page.
2. Copy of extended reporting endorsement (tail) from your current carrier if your current coverage is claims-made and you are *not* applying for Prior Acts Coverage.
3. Loss runs from all prior insurance companies or explanation as to why they are not available.
4. Current business letterhead.

1. Personal Information

Name: ______________________ Degree: ______________

Social Security Number: ______________________ Date of Birth: ______________

Place of Birth: ______________________ Gender: Male ☐ Female ☐

Email Address: ______________________

Home Address: ______________________

City: ____________ State: ______ ZIP: ________ Home Phone: ______________

Dental License Number(s):

State	License Number/NPI Number	Expiration Date	% of Practice

List all National, State and County Dental Associations you currently belong to: ______________________

2. Practice Location

Practice Name: ______________________

Practice Street Address: ______________________

City: ____________ County: ____________ State: ______ ZIP: ________

Kentucky Only: Professional office located within the city limits of: ______________________

Office Phone: ____________ Office Fax: ____________ Website: ______________

Mailing Address: ______________________

Billing Address: ______________________

Contact Name: ______________________ Title: ______________

Contact Email Address: ______________________

Please list other practice locations:

Practice Name: ______________________

Practice Street Address: ______________________

City: ____________ County: ____________ State: ______ ZIP: ________

Dates: ____________ From: ________ To: ________ Percent of Practice: ________

Practice Name: ______________________

Practice Street Address: ______________________

City: ____________ County: ____________ State: ______ ZIP: ________

Dates: ____________ From: ________ To: ________ Percent of Practice: ________

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3. Coverage Requested

A. Requested effective date: ___________ / ___________ / __________
MONTH DAY YEAR

B. Please indicate your desired level of coverage.
Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): ____________ / ______________
Excess Coverage Limits (where available): ____

C. Do you desire coverage for a practice entity? Yes ☐ No ☐
If yes, we require a corporate application to be completed.

4. Prior Acts Coverage

(Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.)

A. Are you requesting Prior Acts Coverage? If no, please skip to Section 5. Yes ☐ No ☐
Retroactive Date: _________ / _________ / __________
MONTH DAY YEAR

B. During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g., different states, procedures, coverages, etc.). Yes ☐ No ☐
If yes, please describe the changes in your practice, including all applicable dates in the space at the end of the application.

5. Education and Training

A. Please list the name and location of all dental schools attended:

Institution and Location	Dates Attended	Degree Obtained

B. Please list any post-graduate training:

Institution and Location	Dates Attended	Degree Obtained

6. Practice Information

A. Do you practice as (check one):
☐ Solo Unincorporated ☐ Partner in a Partnership ☐ Employee
☐ Solo Corporation ☐ Shareholder in a Professional Corporation ☐ Independent Contractor

B. Please check and indicate percentage of time you practice in each. Total must equal 100%:
☐ General Dentistry _________% ☐ Pediatric Dentistry _________%
☐ Endodontics _________% ☐ Periodontics _________%
☐ Oral or Maxillofacial Surgery _________% ☐ Prosthodontics _________%
☐ Orthodontics _________% ☐ Other ___________________ _________%

C. Please check and indicate procedures you perform and percent of your practice:
Oral Surgery: ☐ Minor (Alveolar) _________% ☐ Major (other procedures) _________%
Extractions: ☐ Simple _________% ☐ Full _________% ☐ Partial Bony Impacted _________%
Implants: ☐ Initial Surgical _________% ☐ Restorations _________%
☐ Root Canals _________%
☐ Other _________________________________ _________%
How many hours a week do you practice? ______________________________
Date you established this schedule: _________ / _________ / _________
MONTH DAY YEAR

D. Anesthesia/Sedation

1. Check the type of anesthesia and/or sedation used in your practice and number of procedures done per year in an office or hospital practice, and who administers the anesthesia/sedation.

☐ Local and/or Nitrous Oxide Only
In Office ______________ In Hospital __________
Who Administers: ____________________________

☐ IV/IM Moderate Sedation
In Office __________ In Hospital __________
Who Administers: ________________________

☐ Oral Moderate Sedation
In Office ______________ In Hospital __________
Who Administers: ____________________________

☐ General Anesthesia
In Office __________ In Hospital __________
Who Administers: ________________________

*Please note: If you checked IV/IM sedation, oral moderate sedation, or general anesthesia, we may require a supplemental application to be completed.

2. Please indicate your certification information:
☐ ACLS ☐ BCLS ☐ PALS

3. Do you require that your staff be certified (ACLS, BCLS, or PALS)? ☐ Yes ☐ No

E. Do you teach in a dental school? ☐ Yes ☐ No
If yes, indicate how many hours per week and if coverage is provided through the dental school in the space provided at the end of the application.

F. Do you treat or review treatment of inmates in a correctional institution? ☐ Yes ☐ No
If yes, list the correctional institution, percent of your total practice time, and if coverage is provided through the facility in the space provided at the end of the application.

G. Do you treat patients via a mobile dental unit? ☐ Yes ☐ No
If yes, please list percent of your total practice time: _________%

H. Do you treat or review treatment of patients in a nursing home facility? ☐ Yes ☐ No
If yes, please list percent of your total practice time: _________%

I. Do you treat sleep apnea patients? ☐ Yes ☐ No
If yes, do you ever treat without a physician referral? ☐ Yes ☐ No

J. Do you perform any procedures that are clinical trials, experimental, not usual or customary to the specialty or that are not approved by the ADA or the FDA? ☐ Yes ☐ No
If yes, describe in the space provided at the end of the application.

K. Do you provide elective facial cosmetic procedures, Botox, collagen injections, or other dermal fillers for cosmetic purposes in your practice? ☐ Yes ☐ No

L. Do you perform procedures outside the oral and maxillofacial region? ☐ Yes ☐ No
If yes, describe procedures and number provided per year in the space provided at the end of the application.

M. Do you provide forensics or expert witness testimony? ☐ Yes ☐ No

7. Insurance History and Claim Information

A. Current Insurance Information:

i. Name of Insurer: ____

ii. State Where Practiced: ____________________________________

iii. Policy Limits: ____

iv. Dates Covered, From: ___________________ To: _______________

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. If Claims-Made, Retro Date: _________ / _________ / _________
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Previous Insurance Information:

i. Name of Insurer: ____

ii. State Where Practiced: ____________________________________

iii. Policy Limits: ____

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iv. Dates Covered, From: ____________________ To: ________________

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. If Claims-Made, Retro Date: __________ / __________ / __________
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

C. Previous Insurance Information:

i. Name of Insurer: ____

ii. State Where Practiced: ____

iii. Policy Limits: ____

iv. Dates Covered, From: ____________________ To: ________________

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. If Claims-Made, Retro Date: __________ / __________ / __________
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

D. Will you be carrying additional liability insurance with another company? Yes ☐ No ☐

If yes, provide name of company, limits, expiration date, and services covered in the space provided at the end of the application.

If you answer yes to questions E, F, or G, including any sub-questions, please complete the attached Supplementary Claims Information Form.

E. Have you *ever* been involved in a dental professional liability claim or suit? The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership. Yes ☐ No ☐

F. Other than the situations indicated in 7.E. above, are you aware of any of the following circumstances:

i. A request for records from a patient, family member, attorney, or patient representative related to an adverse outcome or treatment of a patient? Yes ☐ No ☐

ii. A letter from an attorney regarding your treatment of a patient? Yes ☐ No ☐

iii. A patient, family member, or patient representative's dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes ☐ No ☐

iv. Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes ☐ No ☐

G. Have all circumstances in question 7.F. above been reported to your current or prior professional liability carrier? Yes ☐ No ☐ N/A* ☐

If yes, how many? ____________ Please attach documentation of all such reports.

If no, please explain in space provided at the end of the application.

*For purposes of this question, N/A means that you answered "No" to each subpart of question 7.F.

H. 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 ☐

8. Personal History

(If you answer yes to any of the following questions, provide complete details in the space provided at the end of the application or on a separate sheet.)

A. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any mental illness, including but not limited to depression/and/or chronic fatique? Yes ☐ No ☐

B. Are you aware of, or in a treatment program for, any health impairment or disability that may affect your ability to perform professionally? Yes ☐ No ☐

C. Have you ever been convicted of, pled guilty to, or pled no contest to a felony? Yes ☐ No ☐

D. Have you ever been convicted of, pled guilty to, or pled no contest to a violation of any law or ordinance (other than minor traffic offenses), including driving while under the influence of alcohol or any other substance? Yes ☐ No ☐

E. Have you ever failed any licensing or Board Certification examinations? Yes ☐ No ☐

F. Has your license to practice dentistry or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? Yes ☐ No ☐

G. Have you ever appeared before, been investigated by, or entered into any consent agreement with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes ☐ No ☐

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H. Have you ever had a patient or patient representative complain to or file a grievance of any type with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes ☐ No ☐

I. Have you ever voluntarily surrendered your hospital privileges, narcotics or professional license to avoid suspension, restriction, probation, or revocation? Yes ☐ No ☐

J. Has any hospital ever restricted, suspended, revoked, or refused your privileges or has probation ever been invoked? Yes ☐ No ☐

K. Have you ever been accused of sexual misconduct or inappropriate physical contact? Yes ☐ No ☐

ALABAMA FRAUD WARNING – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Consent to Conditions of Consideration of the Application for Insurance

I understand that no coverage will be bound until after ProAssurance has reviewed my completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, my advance payment will be promptly returned to me.

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me.

To the fullest extent permitted by law, I extend absolute immunity to and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I understand that should any incident, injury or death occur to any patient while under my care subsequent to my signing and dating this application, I must notify ProAssurance or its authorized agent or broker in writing of such event.

Name (Printed): ______________________________

Applicant's Signature: ______________________________ Date: ______________

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Applicant's Representation and Authorization which requires your signature. Please read it carefully.

Applicant's Representation and Authorization

I, the undersigned, hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon my acceptability to ProAssurance and its subsidiaries as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I understand that third-party information, records or data regarding my practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name (Printed): ______________________________

Applicant's Signature: ______________________________ Date: ______________

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

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For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

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Dentist's Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Name: ______
2. Date Reported to Insurance Company: ______
3. Name of Insurance Company: ______
4. Name and Address of the Attorney Assigned to Your Case: ______
5. Date of Incident and Your Treatment: ______
6. Allegations: ______
7. What is the present condition of the patient? ______
8. 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 ☐
9. Status of claim (check applicable answer):

☐ Suit threatened, no action taken

☐ Suit filed, but dropped by claimant

☐ Summary Judgment in your favor

☐ Suit settled Out-of-Court
Date claim paid: ______
Amount paid: ______

☐ Court outcome in your favor
☐ Jury verdict
☐ Directed verdict

☐ Court outcome in favor of plaintiff
☐ Jury verdict
☐ Directed verdict
Amount of Loss: ______

☐ Awaiting mediation

☐ Awaiting court action

Reserve Amount: ______

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐
If yes, amount was: $______

Name (Printed): ______

Signature: ______ Date: ______

PROASSURANCE
Treated Fairly

Important Notice About the Policy of Insurance for Which You Have Applied

This Document Affects Your Legal Rights

Read the Following Information Carefully

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

Acknowledgement of Arbitration Agreement

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

Applicant's Signature	Date	Time

Note: You will need to sign this notice to be considered for coverage.