PROFESSIONAL UNDERWRITERS LIABILITY INSURANCE COMPANY
A TDC Company

12121 Wilshire Boulevard, Suite 601 Los Angeles, CA 90025

DENTIST'S & ORAL SURGEON'S PROFESSIONAL LIABILITY POLICY NEW BUSINESS APPLICATION

Instructions: All questions must be answered. Please type or print clearly. No coverage is in place until application is approved and premium paid. All requested explanations and documents must be attached including: current declarations page, CV & currently valued loss runs.

NOTICE
This is an application for a CLAIMS-MADE POLICY

1. (a) Applicant's Full Name:_____ Degree/Title:_____

   Other Name Used:_____ Birth Date:_____

   (b) Social Security #:_____ (c) Federal DEA #:_____ Male ☐ Female ☐

   (d) Home Address:_____ Phone: (_____)_____
   Number Street City County State Zip

   (e) Principal Office:_____ Phone: (_____)_____
   Number Street City County State Zip
   Fax: (_____)_____

   (f) Other Office Address(es):_____ Phone: (_____)_____
   (if any) Number Street City County State Zip
   Email: _____

2. Specify States where you are licensed:

   _____ _____ _____
   (License #) (State of Licensure) (Field) (License #) (State of Licensure) (Field) (License #) (State of Licensure) (Field)

3. Dental Specialty: (check all boxes that apply):

   1. ☐ General Dental Practice 3. ☐ Orthodontics 5. ☐ Oral/Maxillofacial Surgery
   2. ☐ Oral Surgery 4. ☐ Dental Anesthesiology 6. ☐ Other (Describe):_____

4. (a) What is your average weekly patient load?_____ (b) How many hours do you practice each week?_____

5. If my application is approved, make coverage effective on _____, if possible, otherwise on any other date set by the Company.

6. (a) Type of Practice (check all boxes that apply):

   1. ☐ Individual (solo) Unincorporated 4. ☐ Member of Multi-person Corporation or Association 7. ☐ Other (Describe)
   2. ☐ Individual (solo) Corporation 5. ☐ Employee of:_____ _____
   3. ☐ Partnership 6. ☐ Independent Contractor of:_____

   (b) List Federal Taxpayer Identification Number(s) and name(s) of corporate entity(ies):

   _____
   Entity Name Federal Taxpayer Identification Number

   _____
   Entity Name Federal Taxpayer Identification Number

   (c) Please list name(s) of ALL other partners, stockholders, associates, independent contractors and employed dentists or physicians. **(Indicate status of each and provide proof of coverage for each). Please use a separate sheet of paper if necessary.**

   1. _____ 3. _____
   Name Current Limits Name Current Limits
   2. _____ 4. _____
   Name Current Limits Name Current Limits

7. Board Certification: In what area(s) if any are you Board Certified or Eligible?

   (a) Board Certified:_____ Date(s) Certified:_____ ☐ N/A

   (b) Board Eligible:_____ Date(s) Certified:_____ ☐ N/A

   (c) Have you ever failed any dental licensing or specialty organization examination? YES ☐ NO ☐

   If YES, please explain:_____

ATTESTATION QUESTIONS

8. **If the answer to any of the following is YES, please give full details (including dates) on a separate sheet of paper:**	**YES**	**NO**
(a) Have you ever had professional liability insurance declined, canceled, issued on special terms or non-renewed?	☐	☐
(b) Have you ever been investigated or are you currently being investigated by a State Board of Dental Examiners, Board of Dental Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? **(If YES, provide copies of all Accusations, Decisions, Consent Orders, etc.)**	☐	☐
(c) Has or is your license to practice dentistry or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?	☐	☐
(d) Have you ever had privileges at any hospital or other institution denied, reduced, revoked, restricted, or suspended?	☐	☐
(e) Are you currently or have you ever been evaluated, treated or hospitalized for alcohol or drug abuse or a mental or emotional disorder?	☐	☐
(f) Have you ever been convicted of, or are you under indictment for, a felony?	☐	☐
(g) Has your membership in any professional society or association ever been refused, censured, suspended or revoked?	☐	☐
(h) Do you currently have or have you ever had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice?	☐	☐
(i) Are you currently or have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties?	☐	☐
(j) Has any dentist, patient or insurance plan ever filed a complaint against you with any Dental Association/ Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau?	☐	☐
(k) Have you ever been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)?	☐	☐
(l) Have you ever been involved in a malpractice claim, suit or incident, either directly or indirectly, or are you presently involved in malpractice litigation? **(If YES, please complete a Claims Information Form for each.)**	☐	☐
(m) Are you aware of any facts, circumstances, incidents, records requests or letters of intent that may give rise to a claim or suit? **(If YES, please complete a Claims Information Form for each, attached to this Application).**	☐	☐

TRAINING & INSURANCE HISTORY

9. (a) Dental School:_____ Dates:_____
City State Country mm/dd/yy to mm/dd/yy

(b) Residency:_____ Dates:_____
Hospital City State Country mm/dd/yy to mm/dd/yy

(c) Type of Residency:_____

(d) Residency:_____ Dates:_____
Hospital City State Country mm/dd/yy to mm/dd/yy

(e) Type of Residency:_____

List any additional medical specialty training (i.e. Specialty Training, Anesthesia Training, Fellowship, etc.):

Location	Type	Dates

10. Do you anticipate taking any additional residencies or changing your specialty? YES ☐ NO ☐

If yes, please explain:_____

11. List malpractice coverage for the past **10** years, beginning with your current or most recent carrier:

Name of Insurer	Dates Covered From – To (MM/DD/YY)	Limits of Liability	Retro-active Date	Coverage Type (Occurrence or Claims-Made)	Premium	Was Tail Coverage Purchased?	# of Pending Claims	# of Closed Claims	Total # of Claims
A									
B									
C									

1. PLEASE ATTACH A COPY OF YOUR MOST RECENT DECLARATION'S PAGE AND POLICY.

2. PLEASE FILL OUT A CLAIM INFORMATION FORM FOR EACH SUIT, CLAIM, LETTER OF INTENT AND INCIDENT, OPEN OR CLOSED, AND SUBMIT ANY ADDITIONAL INFORMATION RELATIVE TO THESE CLAIMS.

(a) Do you intend to purchase a reporting endorsement (a.k.a. Tail Coverage) from your current insurer? YES ☐ NO ☐

(b) If answer to (a) is NO, do you wish to obtain Prior Acts Coverage from us? **NOTE: The offering of Prior Acts Coverage is subject to Underwriter approval.** YES ☐ NO ☐

(c) If answer to (b) is YES, please attach a copy of your present insurance policy, with all endorsements, and complete the following:

Applicant is/is not **(circle one)** as of this date aware of any Claims, Suits, Letters of Intent, Records Requests or Incidents that have not been reported to his/her **(circle one)** present or prior insurer(s). Please Initial:_____

NOTE: If you do not purchase Prior Acts Coverage from us you will not have any coverage through us for any claim or suit based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued. We strongly urge you to consult your broker to discuss continuity of coverage and the implications thereof.

PRACTICE QUESTIONS

12. (a) Do you treat or review the treatment of prison inmates? YES ☐ NO ☐ % of practice:_____

If YES, please explain (include facility names):_____

(b) Is insurance coverage provided for this work by the above facility? YES ☐ NO ☐

13. Do you treat or consult on patients in any sovereign nation or territory, other than the U.S., such as Native American or Alaskan Native lands?

YES ☐ NO ☐ If YES, where?_____ % of practice:_____

14. List all locations where you have practiced in the last 10 years:

	Group Name	Street	City	County	State	During Years
(a)						
(b)						
(c)						

15. Do you (YES☐ NO☐) or your professional entity (YES☐ NO☐) employ or contract for the services of any health care personnel? If YES, provide number of each and indicate if coverage (shared limits) is desired for each. **NOTE: If employed by an entity, coverage may not be available.**

		# Employed	Is Coverage Desired?		# of Independent Contractors	Are they Insured?	
(a)	Dentists		YES ☐	NO ☐		YES ☐	NO ☐
(b)	Orthodontists		YES ☐	NO ☐		YES ☐	NO ☐
(c)	Oral Surgeons		YES ☐	NO ☐		YES ☐	NO ☐
(d)	CRNA's**		YES ☐	NO ☐		YES ☐	NO ☐
(e)	Dental Hygienists		YES ☐	NO ☐		YES ☐	NO ☐
(f)	X-ray Technicians		YES ☐	NO ☐		YES ☐	NO ☐
(g)	Dental Technicians		YES ☐	NO ☐		YES ☐	NO ☐
(h)	Laboratory Technicians		YES ☐	NO ☐		YES ☐	NO ☐
(i)	Other:_____		YES ☐	NO ☐		YES ☐	NO ☐
(j)	Other:_____		YES ☐	NO ☐		YES ☐	NO ☐

****If YES, please submit a written explanation of practice and procedures performed, along with certificate of course completion and license number. Provide proof of insurance if insured elsewhere. If coverage is desired, please complete a Professional Underwriters Liability Insurance Company Allied Personnel Application for each.**

16. Are you associated in any capacity with, or do you own, any of the following:

(a) A dental laboratory? YES ☐ NO ☐

(b) Any other business enterprise related to dentistry? YES ☐ NO ☐

If answer to (b) is YES, please explain: _____

17. Do you practice dentistry in any hospital, surgery-center or other facility? YES ☐ NO ☐

If YES, please list the facility or facility where dentistry is performed:

	Facility Name	City	County	State	Type of Privileges
(a)					
(b)					
(c)					

18. Do you treat patients in any nursing home, skilled nursing facility or assisted living center? YES ☐ NO ☐

If YES, % of practice: _____ If YES, do you treat other than your own patients? YES ☐ NO ☐

19. Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? YES ☐ NO ☐

If YES, have you implemented procedures to comply with the HIPAA Privacy Rule? YES ☐ NO ☐

20. What % of your patient's are: (a) over age 65? _____ (b) Age 18 or younger? _____

21. Has your practice (e.g. specialty, procedures or practice environment) changed in the last five years? YES ☐ NO ☐

If YES, please explain: _____

Explanations, Remarks & Notes: _____

22. Indicate the percentage of your practice devoted to the following activities:

_____% Dentures
_____% Root Canals
_____% Implants
_____% Extractions (Third Molars)
_____% Extractions (other)
_____% Orthodontia
_____% Periodontal procedures
_____% Other oral surgery **(explain below)**
_____% Bleaching or Whitening
_____% Other dental cosmetic
_____% Elective facial cosmetic surgery (rhinoplasty, face-lifts, skin grafts)
_____% Procedures outside the Oral and Maxillofacial Region except bone harvesting **(explain below)**

Explanations: _____

PROCEDURAL QUESTIONS

For <u>each</u> procedure in Section (a) below, please provide the approximate number of times you have "Performed" or "Assisted" during the past 12 months as well as how many times you anticipate doing so during the next 12 months. If you Perform or Assist in other procedures not listed below, add each one in the "Remarks" section.

23. (a) General Procedures:	**# Performed**		**# Assisted**	
	Past Year	**Next Year**	**Past Year**	**Next Year**
Orthodontic Full Mouth Banding				
Dental Implants				
Surgical Placement **(Explain below)**				
Prosthetic or Restorative				
Nerve Grafts				
Parotid Gland Surgery				
Orthognathic Surgery				
Management of Malignant Lesions				
Cleft Lip and Palate Surgery				
Face Lifts				
Rhinoplasty				
Sleep Apnea Therapy				
Intermaxillary Fixation for Obesity or Weight Control				
Sinus Lifts				
Root Canal Therapy				
Molar Endodontics				
TMJ Surgery				
TMJ Arthroscopy				
TMJ Reconstructive				
TMJ Implants				
Other **(Explain below)**				
Other Dental Surgery				
(Explain type in remarks section)				

Remarks

_____

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23. (b) Anesthesia Information:

Do you treat patients under any of the anesthetic modalities listed below?

(a) None YES ☐ NO ☐

(b) Local Anesthesia YES ☐ NO ☐

(c) Nitrous Oxide analgesia YES ☐ NO ☐

(d) Oral (swallowed) conscious sedation YES ☐ NO ☐

(e) Parenteral conscious sedation (including intravenous or intramuscular) in a hospital, surgicenter or an office administered by a Dentist Anesthesiologist, M.D. Anesthesiologist or Oral Surgeon YES ☐ NO ☐

(f) Parenteral conscious sedation (including intravenous or intramuscular) in a hospital, surgicenter or an office administered by you YES ☐ NO ☐

(g) General anesthesia – in a hospital, surgicenter or an office administered by a Dentist Anesthesiologist, M.D. Anesthesiologist or Oral Surgeon YES ☐ NO ☐

(e) General anesthesia – in a hospital, surgicenter or an office administered by you YES ☐ NO ☐

(f) How many years have you used conscious sedation in your office? _____Years

(g) How many years have you used general anesthesia in your office? _____Years

(h) Do you hold a current ACLS Certificate? YES ☐ NO ☐

(i) Are you and your staff certified in Basic Life Support (CPR)? YES ☐ NO ☐

(j) Are the vital signs of your patients under sedation or general anesthesia being **<u>continuously</u>** monitored? YES ☐ NO ☐

If YES, by whom?

You ☐ CRNA ☐ DDS Anesthetist ☐ Other ☐ **(Explain)**

(k) Which of the following methods do you use in monitoring patients? **Please indicate the appropriate codes based on mode of anesthesia: (S) for Sedation, (G) for General Anesthesia or (B) for Both modalities:**

_____Manual monitoring of blood pressure and heart rate

_____Precordial stethoscope

_____Electronic/automatic monitoring of blood pressure and heart rate

_____EKG Monitor

_____Pulse-oximeter

_____Other (Please specify)_____

(l) Which of the following items do you have available for emergency treatment?

Crash Cart	YES ☐	NO ☐
Ambu Bag	YES ☐	NO ☐
Oral Airway	YES ☐	NO ☐
Oxygen	YES ☐	NO ☐
Endotracheal tubes/scopes	YES ☐	NO ☐
Emergency drugs	YES ☐	NO ☐

NO KNOWN CLAIMS DECLARATION

I declare that I am not aware of, nor do I have any knowledge of, any claim, notice of claim, records request, letter of intent, incident, any unreported conduct, or any circumstance or occurrence which could reasonably be expected to result in a claim against me subsequent to the date of my signature below that I have not already reported to my previous professional liability carrier and which I have not disclosed on my application to Professional Underwriters Liability Insurance Company.

I have reported all claims, and all facts or circumstances that could give rise to a claim to appropriate prior carrier(s) and understand that all such known claims or potential claims will not be covered by this insurance. I also understand that this insurance does not apply to any of the following:

1. Any incident or claim for which I have received notice of a claim.
2. Any incident or claim for which a legal action has been filed against my employees or me.
3. Any incident or claim upon which any companies previously insuring me have previously established a claim file.
4. Any incident or claim arising out of any fact, circumstance, or situation indicating the possibility of a claim which was known to me as of the effective date of insurance for which I am applying.

Signature: **X** _____ Date: ____/____/____

_____
Print Name

WARRANTY & RELEASE

I do hereby warrant the truth of all statements and answers mentioned herein, and that I have not withheld any information which may influence or would influence the judgement of the Company in considering this application for professional liability insurance.

I understand that if the information in this application materially changes between the date of this application and the policy effective date, I will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

I understand and agree that erroneous and/or material misrepresentations or omissions will cause immediate rescission of my insurance coverage.

I understand and agree that the Company will not provide defense or indemnity coverage for any claims, civil lawsuits, arbitration, legal or administrative proceedings, incidents, accidents, or events in which damages or liability is assumed or imposed, or sought to be imposed, upon an insured under a written or oral agreement, specifically including a "hold harmless" indemnification or similar agreement, where the damages or liability assumed by, imposed or sought to be imposed are greater than that which would exist in the absence of such an agreement.

This application form, duly completed, together with any supplementary information, **must** be signed and dated in ink by the applicant. Signature of the form does not bind the applicant or the Company to issue coverage.

Signature: **X** _____ Date: ____/____/____

I understand that in order to underwrite professional liability insurance, the Company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any dental society, dentist, medical doctor, hospital, preceptorship, residency program, insurance company, underwriter and insurance agent/broker to furnish any information concerning me or my dental practice which the company, or its representative may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction, together with the agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even if the information is wrong.

Signature: **X** _____ Date: ____/____/____

CLAIMS INFORMATION FORM

CLAIM INFORMATION - Please type or print clearly

1. Name of Patient:_____ 2. Age:_____ 3. Sex:_____

4. Your relationship to patient (e.g. primary dentist, consultant, assistant, accepted referral):_____

5. Allegation(s) (as stated by patient/plaintiff):_____

6. Date of Incident:_____ 7. Date Reported to Carrier:_____ 8. Location:_____

9. Insurance Carrier(s):_____

10. Other Defendants:_____

11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES ☐ NO ☐

12. Present Status: _____Incident Only _____Pending Suit _____Closed

Date Closed:_____ Amount Paid:_____ Settlement or Judgment (circle one)

13. Condition and diagnosis at time of treatment:_____

14. Dates and description of treatment rendered:_____

15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT):_____

16. Defense Counsel:_____

17. Plaintiff's Counsel:_____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X**_____ Date:____/____/____

CLAIMS INFORMATION FORM
(Please make additional copies if needed)

CLAIM INFORMATION - Please type or print clearly

1. Name of Patient:_____ 2. Age:_____ 3. Sex:_____

4. Your relationship to patient (e.g. primary dentist, consultant, assistant, accepted referral):_____

5. Allegation(s) (as stated by patient/plaintiff):_____

6. Date of Incident:_____ 7. Date Reported to Carrier:_____ 8. Location:_____

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14. Dates and description of treatment rendered:_____

15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT):_____

16. Defense Counsel:_____

17. Plaintiff's Counsel:_____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X**_____ Date:____/____/____

NOTICE:

The underwriter is authorized to make any inquiry in connection with this application. The underwriter's acceptance of this application or the making of any subsequent inquiry does not bind the applicant or the underwriter to complete the insurance or issue a policy.

If the information in this application materially changes between the date of this application and the policy effective date, the applicant will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Applicants: 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.

Maine Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Missouri Applicants: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Applicants: 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 civil and criminal penalties.

Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Applicants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania Applicants: 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 subjects such person to criminal and civil penalties.

Tennessee Applicants: 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.

Virginia Applicants: 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 and civil damages.

West Virginia Applicants: 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.