

2. TYPE OF PRACTICE

a. Have you completed a General Practice Residency Program? Yes No

NAME OF HOSPITAL	YEAR COMPLETED
SPECIALTY	YEAR SPECIALTY TRAINING COMPLETED
SPECIALTY SCHOOL ATTENDED	

b. Do you perform cosmetic surgery, liposuction, botox or derma fillers? Yes No

c. How many hours per week do you practice dentistry? _____

d. Are you a full-time member of a dental school faculty? Yes No
 If **yes**, you must attach a letter from the school verifying your full-time appointment to receive faculty discount.

e. Are you a full-time student enrolled in an accredited dental postgraduate program? Yes No
 If **yes**, you must attach a letter from the school verifying your full-time student status to receive the postgraduate discount.

f. As which of the following do you provide professional services?
 Owner Associate Employee or Ind. Contractor Partner or Shareholder Other, please describe: _____

g. Have you completed a professional liability risk management/loss prevention course in the last two (2) years? Yes No

_____ If **yes**, please list course title, sponsor, length of program and date completed.

3. For each of your practice location(s), please provide a list of the names of dentists present at that location, including dentists who only perform hygiene procedures, and your business relationship with each dentist (i.e., employee, employer, independent contractor, associate, partner or shareholder). Our underwriting guidelines require confirmation of professional liability insurance for dentists who work with you. Please provide the name of each dentist’s insurance carrier. We only insure dentists who work with insured dentists. Please use additional sheets if necessary.

Associates (listed below) Working Interviews Not applicable (no other dentist present)

NAME	ADDRESS	BUSINESS RELATIONSHIP TO YOU SEE ABOVE	NAME OF PROFESSIONAL LIABILITY CARRIER

4. STATE DENTAL ASSOCIATION OR SOCIETY

Are you a member or applicant of your state dental association or society? Yes No

ADA NO.	LOCAL DENTAL SOCIETY
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5. Please provide the name(s) of your professional liability carrier(s) for the past five years, including policy period and type of policy.

INSURANCE CO.	CERTIFICATE/POLICY NO.	COVERAGE DATES	TYPE OF POLICY (O=OCCURRENCE/CM=CLAIMS-MADE)

ATTACH A COPY OF YOUR MOST RECENT INSURANCE DECLARATIONS PAGE(S), INCLUDING YOUR PRIOR ACTS OR RETROACTIVE DATE.

6. Are you now practicing or have you ever practiced without professional liability insurance? Yes No

If yes, please give details.

7. Has any insurer ever cancelled, declined or modified coverage (i.e., reduced limits, assigned a deductible, restricted coverage, or surcharged rates) or refused renewal of your professional liability insurance? Yes No

If yes, please give details.

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

- None
 Local anesthesia
 N₂O/O₂ analgesia
 Oral conscious sedation
 Conscious sedation (including IV or IM) or general anesthesia in a hospital or surgi-center, administered by dentist anesthesiologist, M.D. anesthesiologist or oral and maxillofacial surgeon
 Conscious sedation (including IV or IM) in office Who Administers? _____
 General anesthesia in office Who administers? _____

9. What type of informed consent do you use? Oral Oral/Chart noted Written

10. Does your practice include spa dentistry? Yes No

11. Do you perform sleep apnea/snoring therapy? Yes No
 If yes, do you treat after a physician's referral? Yes No

12. **DESIRED LIMIT OF LIABILITY** (*Check one only*)

- \$500,000 per occurrence/\$1,500,000 aggregate per policy year
 \$1,000,000 per occurrence/\$3,000,000 aggregate per policy year
 \$1,500,000 per occurrence/\$4,500,000 aggregate per policy year
 \$3,000,000 per occurrence/\$3,000,000 aggregate per policy year
 \$5,000,000 per occurrence/\$5,000,000 aggregate per policy year

13. Do you have ownership interest in a multiperson corporation or partnership? Yes No

Name of corporation or partnership

14. Type of Identity Recovery Coverage desired? Individual Family



15. Has any governmental or licensing agency ever investigated you, suspended or revoked your license, placed you on probation, imposed any fine or penalty or taken any other action against either your narcotics license or your license to practice dentistry? Yes No

If **yes**, please give details.

16. Have you ever been indicted or convicted of a crime other than minor traffic violations?..... Yes No

If **yes**, please give details.

17. Have any Medicare/Medicaid fraud charges ever been filed against you? Yes No

If **yes**, please give details.

18. Do you have any personal health problems including alcoholism, narcotics addiction or mental illness? Yes No

If **yes**, please attach a statement from your treating physician regarding the status of your health problem.

19. Are you aware of any incident(s) that you have reason to believe could give rise to a claim in the future? Yes No

If **yes**, please give details.

20. Within the preceding five years, has any claim or allegation of malpractice been asserted against you? Yes No
If **yes**, complete one form for each claim, suit, allegation or incident. Please photocopy this section, if necessary. Answer all questions completely.

Name of patient/claimant

City/State where incident occurred

Allegation

Were you insured? Yes No

Name of Insurer

Date(s) of alleged occurrence

Date incident/claim/suit reported to insurance company

Current status

If open, amount of reserve

If closed, amount of total settlement or judgment

Date closed

Amount paid on your behalf

Please provide a narrative description of the claim or allegations, including nature of treatment, your involvement, etc. If no payment was made, how was the matter concluded?
(Please attach additional sheets as needed.)

EXCLUSION

Any policy issued in response to this application will exclude:

- (a) Liability arising out of any incident, which at the time coverage begins, you have reason to believe could give rise to a future claim that you do not disclose in response to question 19; and
- (b) Liability arising out of any allegation or claim of malpractice, which at the time coverage begins, you have reason to believe could give rise to a future claim that you do not disclose in response to question 20.



Employment Practices Liability Insurance (Optional Coverage)

Please read this before filling out your application for Employment Practices Liability Insurance.

NOTICE: Employment Practices Liability coverage, if provided in response to this Application, will apply ONLY to those claims for employment related acts which, at the beginning of the policy period, you could not reasonably have foreseen giving rise to a claim during the policy period. Further, the policy will exclude any claim relating in any way to any act, omission, fact or circumstances required to be disclosed in this Application, or in any later renewal questionnaire, whether or not you actually disclose the required information.

Desired Limit of Liability (check one) \$50,000 \$100,000

1. Number of employees at all locations excluding family members:

	FULL TIME	PART TIME
HYGIENISTS		
DENTAL ASSISTANTS		
PARTNERS OR SHAREHOLDERS		
OTHER OFFICE STAFF		
OTHER DENTISTS WHO ARE INDEPENDENT CONTRACTORS OR EMPLOYEES		

2. Do any of the employee dentists above work under a contract that gives them the right to take over the practice? Yes No

3. Have you terminated, demoted, or disciplined an employee or independent contractor within the past five (5) years? Yes No

If **yes**, please list the employee's name, date and give a brief explanation of the action taken.

4. Other than disclosed in questions 3, have you had any employment-related claims, allegations or incidents within the past two (2) years? Yes No

If **yes**, please list by name and describe all employment-related claims, allegations or incidents you have experienced within the past two (2) years. Include any settlement amount or final determination amount of the claim(s) and the date.
Example: wrongful termination or discrimination.

5. In your office, do you have written procedures in place with regard to the following:

Termination Yes No

Hiring Yes No

Discipline Yes No

Do you have a standard employment application for all applicants? Yes No

Do you have an employment handbook? Yes No

Do you have an "At Will" provision in the employment application or handbook? Yes No

Do you have a written policy with respect to sexual harassment? Yes No

Do you have a written policy with respect to discrimination? Yes No

Do you have written annual performance evaluations for employees? Yes No

If **yes**, are the evaluation documents in writing and signed by the employees? Yes No

Do you have written procedures for handling employee complaints regarding harassment or discrimination? Yes No

Do you post the required federal and state regulations? Yes No



I authorize release and exchange of information between my past and present dental society, the state dental association or society and their insurance consultants, any hospital where I presently hold or previously held staff privileges, prior professional liability insurance carriers and their agents, previous attorneys of record in any liability actions or claims, any government agency, and The Dentists Insurance Company (TDIC) involving past or future underwriting and claims matters. I hereby represent and warrant the truth of my statements and representations made herein, and that I have not withheld any information that is reasonably likely to influence the judgment of the company in considering this application for professional business liability insurance and/or employment practices liability insurance.

I agree to notify TDIC of any change in the information contained in this application—before and after a policy is issued—and to supply such further underwriting information as TDIC may require.

I hereby certify that I have reported to my present or previous insurance carriers all known claims and all incidents, which I have reason to believe could become claims, and have disclosed in this application my knowledge of any threatened litigation of existing facts, or situations which could result in a claim being filed against me.

Any insurance issued in response to this application is void if an insured has concealed or misrepresented any material fact or circumstances relating this insurance at any time prior to issuance or renewal of the policy.

PRINT NAME

SIGNATURE OF APPLICANT

DATE

Return this application by mail or fax.

MAIL TO: The Dentists Insurance Company
P.O. Box 1582
Sacramento, CA 95812-1582

FAX TO: 916.554.5957

Questions? Call your local broker:

Alaska – 907.276.7667, Conrad-Houston Insurance
California, Illinois, Nevada – 800.733.0633, TDIC Insurance Solutions
Hawaii – 808.521.1841, Jerry Hay, Inc.
New Jersey – 877.476.4588, Mid-Atlantic Insurance Resources
Pennsylvania – 877.732.4748, PDAIS, Inc.
All other states – 800.733.0634, TDIC

Online: www.thedentists.com

FRAUD WARNINGS

New Jersey Professional & Business Liability Application Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Pennsylvania Professional & Business Liability Application 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.