

**Newly Licensed & Never Practiced
Application for Claims-Made Coverage
Professional & Business Liability Insurance**



Please read this before filling out your application for Professional & Business Liability insurance.

You warrant and represent that the following statements are yours and that you know the statements to be true. You know and intend that we will rely on the truth of the information you have provided in deciding to issue a policy to you, and that providing any false information in this application is grounds for us to deny you insurance.

Desired Coverage Date: ____ / ____ / ____

1. CONTACT AND OTHER PROFESSIONAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
Professional Degree <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> Other		
Birth Date: ____ / ____ / ____		
PRIMARY PRACTICE LOCATION		
MAILING ADDRESS, IF DIFFERENT FROM PRACTICE ADDRESS		
TAX ID NO. /SSN	E-MAIL ADDRESS	
OFFICE PHONE NO.	ALTERNATE PHONE NO.	FAX NO.
DENTAL LICENSE NO.	STATE	EXP. DATE
DENTAL SCHOOL	YEAR GRADUATED	YEAR FIRST BEGAN PRACTICING IN U.S.

Do you hold a dental license in other states? Yes No

If **yes**, list the states in which you hold a dental license.

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 or liposuction, botox or derma fillers? Yes No

c. 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.

d. 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.

e. Are you planning on practicing less than 21 hours per week on average? Yes No If yes, how many hours? _____

f. Have you completed a TDIC Senior Transition Risk Management seminar in the last year? Yes No



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)

ASSOCIATE	RELATIONSHIP TO YOU	INSURANCE CARRIER
ASSOCIATE	RELATIONSHIP TO YOU	INSURANCE 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. Have you ever practiced without professional liability insurance? Yes No

6. 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? _____

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

8. 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

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

10. Type of Identity Recovery Coverage desired?..... Individual Family

11. Has any governmental or licensing agency ever taken any action against your license to practice dentistry?..... Yes No

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

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

14. Have you had any professional liability claims or are you aware of any incident(s) that you have reason to believe could give rise to a claim in the future?..... Yes No