



**Application for Claims-Made Coverage  
Professional & Dental Business  
Liability Insurance**

The Dentists Insurance Company  
1201 K Street, 17th Floor, Sacramento, CA 95814



- e. 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 the faculty discount.*
- f. 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.*
- g. As which of the following do you provide professional services?  
 Owner    Associate    Employee or Ind. Contractor    Partner or Shareholder  
 Other, please describe: \_\_\_\_\_
- h. 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. 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

**4.** Please provide the name(s) of your professional liability carrier(s) for the past five years, including policy period and type of policy.

Insurance Company	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.**

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

\_\_\_\_\_  
*If yes, please give details.*

**6.** 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.*

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

- None    Local anesthesia    N<sub>2</sub>O/O<sub>2</sub> analgesia    Oral conscious sedation
- Conscious sedation (including IV or IM) or general anesthesia in a hospital or surgicenter, administered by a dentist anesthesiologist, M.D. anesthesiologist, CRNA or oral and maxillofacial surgeon
- Conscious sedation (including IV or IM) in office  
Who administers? \_\_\_\_\_ Specialty? \_\_\_\_\_
- General anesthesia in office  
Who administers? \_\_\_\_\_ Specialty? \_\_\_\_\_

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8. Does your practice include spa dentistry? .....  Yes  No

9. Do you perform sleep apnea/snoring therapy? .....  Yes  No

*If yes, do you treat after a physician's referral? .....  Yes  No*

10. 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

11. Do you practice as a partner in a dental partnership? .....  Yes  No

*If yes, name of partnership.*

12. Do you practice as an officer, director, or shareholder of a multiperson\* dental corporation? .....  Yes  No

*If yes, name of corporation (\*not applicable to sole corporations).*

13. Type of Identity Recovery Coverage desired? (Optional) .....  Individual  Family  None

14. 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.*

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

*If yes, please give details.*

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

*If yes, please give details.*

17. 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(s).*

18. 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.*

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**19.** 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 18; and/or
- (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 19.

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**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     Coverage not desired

**1.** Is this coverage replacing an existing Employment Practices Liability policy? .....  Yes  No

*If yes, please include a copy of your current Employment Practices Liability Insurance declaration page including your Employment Practices Liability prior acts or retroactive date.*

**2.** 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		

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

**4.** 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.*

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**5.** Have you had any employment-related allegations, claims, suits or complaints to government agencies in the past (2) years? .....  Yes  No

*If yes, then please list each one by the name of the employee and the nature of the allegation, claim, suit or complaint. Include the amount of any settlement or judgment and its date.*

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**6.** Other than as disclosed in Question 4, are you aware of any employment-related incidents that you have reason to believe could result in a claim in the future? .....  Yes  No

*If yes, please provide the employee's name and the date and details of the incident.*

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7. Has any insurer ever cancelled, declined or refused renewal of your employment practices liability insurance? .....  Yes  No

*if yes, please provide details.*

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8. 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

**AUTHORIZATION**

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. SIGNING THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE CONTRACT. HOWEVER, IF A POLICY IS ISSUED, THIS APPLICATION WILL BECOME PART OF THE POLICY.

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.

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Print Name	Signature of Applicant	Date (mm/dd/yy)
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**Return this application by mail or fax.**

**Mail to:**

**Fax to:**

**Online:**

**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

**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.