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

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

Please type or print
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 | M.I.

Professional Degree ☐ DDS ☐ DMD ☐ Other Birth Date _____ / _____ / _____

Primary Practice Location

Mailing address, if different from practice address

Tax ID No. / SSN | Email Address | Practice Website

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**, please complete the table below and provide comments if necessary.*

State	Have you or will you practice in this state?	Dates of practice from mm/yy to mm/yy
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Additional Comments: _____

2. Type of Practice

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

Name of Hospital | Year Completed

b. Have you completed a Specialty Program? ..... ☐ Yes ☐ No

Specialty | Specialty School Attended | Year Specialty Training Completed

c. Do you perform cosmetic surgery, liposuction, or dermal fillers (like Botox®)? ..... ☐ Yes ☐ No

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

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. Have you ever practiced without professional liability insurance? ..... ☐ Yes ☐ No

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

☐ None ☐ Local anesthesia ☐ N_2O/O_2 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? _____

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

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

7. 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

**New Dentist Program rate applies only to the $1M/$3M coverage limit.*

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

_____
*If **yes**, name of partnership.*

9. 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).*

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

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

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

13. 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

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

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

EXCLUSION

Any policy issued in response to this application will exclude liability arising out of any incident, 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 13.

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. 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.

Print Name | Signature of Applicant | Date (mm/dd/yy)

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.