

National Casualty Company

Madison, Wisconsin

Property/Casualty Home Office

8877 North Gainey Center Drive • Scottsdale, Arizona 85258

1-800-423-7675 • Fax (480) 483-6752

INDIVIDUAL APPLICATION FOR CLAIMS-MADE DENTISTS PROFESSIONAL LIABILITY INSURANCE

The following are representations of facts known by you to be true. You agree that any coverage issued will be contingent upon the truth thereof and upon final approval by the Underwriters at National Casualty Company. If a policy is issued, this application will become a part of the policy. Please fully complete this application, as an incomplete application cannot be evaluated.

I. ABOUT YOU

1. Name: _____

2. Date of Birth: _____ 3. Social Security No.: _____

4. Professional Degree: DDS DMD Other

5. Name of Practice: _____

6. Primary Practice Location: _____
Street

_____ City County State Zip

IF YOU OWN MORE THAN ONE LOCATION PLEASE COMPLETE THE MULTI-DENTIST SUPPLEMENT.

7. Mailing Address if Different from Above: _____
Street

_____ City County State Zip

8. Office Telephone No.: _____ 9. Fax No.: _____

10. Residence Telephone No.: _____ 11. E-Mail Address: _____

12. Dental School: _____

13. Year Graduated: _____ 14. Date You Began Practice: _____

15. Specialty School (if any): _____

16. Year Graduated: _____ 17. Specialty: _____

18. Dental/Medical License Number(s): _____ State(s): _____ Expiration Date(s): _____

Please supply copy of license(s).

19. Please provide the name(s) of your professional liability carrier(s) for the last three years, policy number, limits and coverage date. Check if claims-made or occurrence.

Insurer	Premium	Policy No.	Policy Limits	Coverage	Type
					<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
					<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
					<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence

ABOUT THE PROPOSED POLICY

20. Requested coverage effective date: _____ Retroactive Date: _____

21. LIMITS OF LIABILITY DESIRED (PER CLAIM/AGGREGATE) Some limits are not available in certain states.

- \$100,000/\$300,000 \$200,000/\$600,000 \$500,000/\$1,500,000
- \$1,000,000/\$3,000,000 \$2,000,000/\$4,000,000 \$3,000,000/\$3,000,000

22. ENTITY LIABILITY COVERAGE

- a. SHARED LIMIT: Entity Liability Coverage with shared limits of liability will be provided at no additional premium charge.
- b. SEPARATE LIMIT: A separate limit of liability is available for the Entity. If you wish to have a separate limit, please check "Yes." If you do not wish to have a separate limit, please check "No." ONE OR THE OTHER OF THESE BOXES MUST BE CHECKED..... Yes No

If you checked "Yes" to question 22.b., please complete the following information:

Full Name of Entity: _____

List all dentists in the practice and complete the information requested below:

Name	Current Insurer	Limits of Liability	Expiration Date of Current Insurance

23. Have you practiced without professional liability insurance in the last ten (10) years? Yes No
If "Yes", explain in remarks section.

24. Has there been a professional liability claim or suit (settled or pending) made against you within the last five (5) years?..... Yes No
If "Yes", complete claim/incident supplement.

25. Do you have knowledge of any dental incident or activity which might give rise to a claim against you that you haven't reported to your professional liability insurance company? Yes No
If "Yes", complete claim/incident supplement.

26. Has any insurer canceled, declined, rescinded or modified coverage, or refused renewal? Yes No
If "Yes", explain in remarks section.

27. Has any governmental, peer review committee, hospital, professional association, patient or licensing agency ever investigated you, or suspended, revoked, placed on probation, reprimanded or taken any other action against you, your narcotics license or your license(s) to practice dentistry? Yes No
 If "Yes", provide copies of decree.

28. Do you have or have you had any physical disability or injury, personal health problems, including alcoholism, narcotics addiction or mental illness which affected your ability to practice dentistry? Yes No
 If "Yes", explain in remarks section.

II. ABOUT YOUR PRACTICE

29. **Are you practicing as an:**

- Employee Owner/Officer/Partner Independent Contractor Other (Explain): _____

Type of Practice (check all that apply):

- Individual Partnership Corporation Limited Liability Company
 Limited Liability Partnership Other (Explain): _____

IF YOU OWN OTHER LOCATIONS, PLEASE COMPLETE THE MULTI-DENTIST SUPPLEMENT.

30. **List the locations where you work or have ownership interest:**

Legal Practice Name	Name of Owner	Address	No. of DDS's at location

31. **List the percentage of your practice time at each location:**

Location 1	Location 2	Location 3	Location 4

32. Do you currently practice part-time? Yes No
 If "Yes", do you anticipate returning to full-time practice in the next six (6) months? Yes No

33. Are you a full-time dental school faculty member? Yes No

34. Are you a full-time student enrolled in an accredited dental post-doctoral program? Yes No

35. Have you taken a Risk Management Course or Seminar during the last three (3) years? Yes No
 If "Yes", please provide a copy of completion for a possible credit.

36. Number of patients **YOU** treat per week: _____

37. What percentage of those patients are under age sixteen (16)? _____ %

38. Number of hours **YOU** practice per week: _____

39. **Number of dental office personnel:**

- Employed Dentists/OMS: _____ Employed Dental Hygienists: _____
 Employed Dental Assistants: _____ Independent Contractor Dentists/OMS: _____
 Independent Contractor Dental Hygienists: .. _____ Independent Contractor Dental Assistants: _____

III. OFFICE PROCEDURES

40. What type of informed consent do you use? Oral Written None
If oral, is chart noted, dated and initialed by patient? Yes No

41. Do you obtain a complete patient medical history? Yes No

Please attach a copy of your medical history form.

42. How often do you or your staff update patient histories? Each visit Occasionally No Policy

If occasionally, what is your procedure? _____

Anesthesia / Analgesia:

43. Are patients treated in your office with **nitrous oxide/oxygen** and/or **oral premedication**? Yes No

If "Yes", who administers the anesthesia? You Another dentist Anesthesiologist or CRNA

44. Are patients treated in your office under **conscious sedation**? Yes No

If "Yes", who administers the anesthesia? You Another dentist Anesthesiologist or CRNA

IF IV, IM OR GENERAL ANESTHESIA IS USED, PLEASE FILL OUT ANESTHESIA SUPPLEMENT.

IV. ABOUT YOUR PROCEDURES

45. Are you a: General Dentist or Specialist

Please list Specialty: _____

If you are a Specialist and also perform procedures in another area of dentistry, please specify the area(s) and please estimate the time spent practicing in these areas: _____

46. During the typical practice **MONTH**, what percentage of your practice is devoted to exams, x-rays, fluoride, prophylaxis, patient education, pit and fissure sealants, single-unit fillings, and patient management? _____ %

47. If you are a General Dentist, do you spend twenty-five percent (25%) or more of your practice time performing procedures within a specialty area? Yes No

If "Yes", please specify below:

Specialty area: _____ Amount of practice time: _____ %

Specialty area: _____ Amount of practice time: _____ %

48. Do you currently use the Sargenti technique? Yes No

Have you ever used the Sargenti technique? Yes No

If "Yes", when did you last use it? _____

49. Do you perform any oral surgery procedures? Yes No

If "Yes", please specify which procedure below:

Simple extractions

Third molar extractions

Soft tissue impactions

Partial bony impactions

Total bony impactions

Describe any other surgical procedures **YOU** perform, including surgical periodontic procedures:

I understand that in order to underwrite professional liability insurance, the Company must have access to information concerning my personal and professional life. I hereby authorize and direct any dental society, dental professional, hospital, residency program, insurance company, underwriter, insurance agent or other entity to furnish any information concerning me or my dental practice which the Company may request. I understand that any policy issued will rely on the truth of the statements and representations I have made herein and that misrepresentations that are fraudulent, or such that the Company would not have issued the policy if the true facts had been known, may result in a denial of coverage for any claim which may be made under this insurance.

I understand that by completing and submitting this application for insurance, I am also applying for membership in the Dental Professionals Purchasing Group, a risk purchasing group formed for the sole purpose of providing professional liability insurance to dentists. My sole purpose in becoming a member is to purchase professional liability insurance.

FRAUD WARNING: 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.

Applicant's Signature

Date

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

Please attach a copy of:

- **Your current insurance Declarations page including retroactive date.**
- **Your current license(s) showing future expiration date(s).**
- **Your Patient Medical History form.**
- **Certificate of Completion of risk management course or seminar within the last three years for possible premium credit.**