



**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     
  \$1,300,000/\$3,900,000     
  \$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 Has any insurer canceled, declined, rescinded or modified coverage, or refused renewal?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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
50. Do you provide any implant services? .....  Yes  No  
If "Yes", complete implant supplement.
51. Do you perform comprehensive or surgical TMJ/TMD procedures? .....  Yes  No  
If "Yes", complete TMJ/TMD supplement.
52. Do you use lasers? .....  Yes  No  
If "Yes", complete laser supplement.



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.

**APPLICABLE IN THE STATE OF NEW YORK:**

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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Applicant's Signature

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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.**