Application Instructions

If you have been uninsured prior to applying for coverage, please include an explanation for the period of time that you have been uninsured:

Are you applying for Claims-Made coverage with prior acts? If so, we must receive a copy of your current policy or a certificate of insurance that includes you prior acts date (also known as retroactive date).

Please be certain to include copies of patient health history and informed consent forms used in your practice.

If you have had claims, please include complete information about the claims, including the date services were rendered, the date the claim was made, the amount paid or the amount in reserve and the status of the claim, is the claim still open, closed without payment or closed with payment.

Additional Forms May be Required:

Part-Time: If you are practicing less than 20 hours and you request the Part-Time discount, a Part-Time Supplement must be completed and submitted.

Implants. If you answer question D6 Yes, an implant supplement must be completed and submitted with your application.

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Dentist's Advantage
PROFESSIONAL LIABILITY & PRACTICE PROTECTION

Policy Application

NOTICE TO APPLICANTS FOR DENTAL PROFESSIONAL LIABILITY COVERAGE ON A CLAIMS MADE BASIS:
The dental professional liability coverage applied for is limited generally to liability for only those claims which arise from dental incidents taking place on or after the retroactive date of the policy and which are first made against the Insured and reported to the Company in writing during the policy period or any applicable reporting period. Please discuss with your insurance agent or broker.

A. GENERAL INFORMATION

Fireman's Fund Insurance Companies, 777 San Marin Drive, Navato, CA 94998

Please type or print. EVERY ITEM MUST BE COMPLETED. If not applicable, write N/A. If additional space is required, please attach additional sheet.

1. _____ NAME OF DENTIST
1a. _____ SOCIAL SECURITY NUMBER
1b. ____/____/____ BIRTH DATE

2. _____ NAME OF PRACTICE
2a. _____ NAME OF PRIMARY CONTACT

3. **PRIMARY MAILING ADDRESS:**
_____ STREET _____ CITY _____ COUNTY _____ STATE _____ ZIP

4. **PRIMARY OFFICE LOCATION/ADDRESS:**
_____ STREET _____ CITY _____ COUNTY _____ STATE _____ ZIP

5. **ADDITIONAL PRACTICE LOCATIONS:**
_____ STREET _____ CITY _____ COUNTY _____ STATE _____ ZIP
_____ STREET _____ CITY _____ COUNTY _____ STATE _____ ZIP

CONTACT INFORMATION:

6a. (____) _____ BUSINESS PHONE NUMBER
6b. (____) _____ RESIDENCE PHONE NUMBER
6c. (____) _____ CELL PHONE NUMBER
6d. (____) _____ FAX NUMBER
6e. _____ E-MAIL ADDRESS
6f. _____ WEB PAGE URL

B. COVERAGE INFORMATION

1. When did you start private practice? ____/____/____ (M D Y)

2. Requested Effective Date: ____/____/____ (M D Y)

3. ☐ Claims Made Coverage OR ☐ Occurrence Coverage

3a. If Claims Made coverage: Please include a copy of your current declarations page AND provide retroactive date: ____/____/____ (M D Y)

4. Coverage Options: Please check the coverage Options and Limits you desire:

☐ **Option 1** Dental Professional Liability Only

☐ **Option 2** Dental Professional Liability and Business Liability Coverages including General Liability, Employee Benefits Liability, Employment Practices Liability, Hired/Non-Owned Automobile Liability and Medical Waste Legal Expense Reimbursement.

Business Owners and Workers' Compensation coverage can also be purchased. Please complete separate application(s).

DENTAL PROFESSIONAL LIABILITY LIMITS

☐ 1. $500,000/$1,500,000 ☐ 2. $1,000,000/$3,000,000 ☐ 3. $2,000,000/$6,000,000

Other limits may be available upon request

5. a. Current Insurer: _____ NAME OF INSURANCE COMPANY **b.** $_____ LIMITS OF LIABILITY **c.** $_____ ANNUAL PREMIUM

6. In which state(s) are you licensed to practice and what percentage of time do you practice there?

a. _____ STATE _____ LICENSE # _____ % OF PRACTICE
b. _____ STATE _____ LICENSE # _____ % OF PRACTICE

7. Are you a member of the AGD?..... ☐ Yes ☐ No

a. If "Yes", AGD Membership Number _____

b. AGD Fellowship?..... ☐ Yes ☐ No

c. AGD Mastership?..... ☐ Yes ☐ No

8. Are you an active member of your state dental association or any other accredited dental association(s)?..... ☐ Yes ☐ No
If "Yes", please provide the name of the association(s):

_____

C. EDUCATION

1. List your training and education.
(If more space is required, use a separate sheet of letterhead or paper).

a. _____ _____
DENTAL SCHOOL — DATE COMPLETED

_____ _____ _____
CITY — STATE — COUNTRY

b. _____ _____
INTERNSHIP LOCATION — DATE COMPLETED

c. _____ _____
RESIDENCY LOCATION — DATE COMPLETED

2. Board Certification: In what area(s) (if any) are you Board Certified or Eligible?

a. _____ DATE: ___/___/___ ___N/A
BOARD CERTIFIED — M D Y

b. _____ DATE: ___/___/___ ___N/A
BOARD ELIGIBLE — M D Y

3. Drug License: _____
DEA NUMBER

4. Have you participated in a risk management program within the last 12 months? ..... ☐ Yes ☐ No
If "Yes", please provide copy of certificate or course name and description.

5. Please describe current certification in cardiac life support and other emergency medical care and indicate date of last certification:

_____

_____

_____

_____

_____ DATE: ___/___/___
M D Y

D. YOUR PRACTICE

1. Do you own your own practice? ..... ☐ Yes ☐ No
(If "No", Skip to Question 2)

a. _____ **b.** #_____
NAME OF BUSINESS — IRS NUMBER

c. Are you incorporated? ..... ☐ Yes ☐ No If "Yes", date of incorporation ___/___/___/

d. Do you employ other dentist(s)? ..... ☐ Yes ☐ No If "Yes", how many dentists in practice _____

e. Are other dentist(s) under contract with you to provide services? ..... ☐ Yes ☐ No
If "Yes", please provide a copy of the current Professional Liability Declaration Page for each.

f. Do you share, lease or own office space with another dentist? ..... ☐ Yes ☐ No

g. How many operatories does your office have? _____

h. Do you employ or contract any dental auxiliary or other office staff? ..... ☐ Yes ☐ No If "Yes", please provide the number of each employed:
_____ Dental Assistants _____ Dental Hygienists _____ Nurse Anesthetists _____ Lab Technicians _____ Other Office Staff

2. a. Are you a salaried employee of another dentist? ..... ☐ Yes ☐ No

b. Are you providing services under contract to another dentist? ..... ☐ Yes ☐ No

c. Are you associated with another dentist? ..... ☐ Yes ☐ No
If you answered "Yes" to any item in 2 above, please provide a copy of the Practitioner's current Professional Liability Declaration Page.

3. Are you associated with a physician or surgeon? ..... ☐ Yes ☐ No

4. Do you serve as a faculty member at a dental school? ..... ☐ Yes ☐ No
If "Yes" you may be eligible for a premium discount. Please include a letter acknowledging your position from the dental school.

5. Please confirm your current dental degree/specialty certification:

☐ General Dentistry ☐ Periodontist ☐ Oral Pathologist ☐ Endodontist ☐ Prosthodontist ☐ Pediatric Dentist ☐ Orthodontist
☐ Dentist Anesthesiologist ☐ Public Health ☐ Oral & Maxillofacial Surgeon ☐ Oral & Maxillofacial Radiology

6. Please confirm the current percentages of your practice that fall into the following categories of care (must total 100%):

_____ % Endodontics _____ % Orthodontics _____ % Gnathology _____ % Pediatric Dentistry
_____ % Oral Pathology _____ % Periodontics _____ % Oral Surgery – simple extractions _____ % Prosthodontics
_____ % Restorative Dentistry (including non-surgical TMJ treatments, simple bleaching, treatment planning, etc.)

7. Does your practice provide spa services to your patients? ..... ☐ Yes ☐ No
If "Yes", please provide details on separate sheet of paper.

8. Please confirm if you currently perform any of the following dental techniques or procedures:

☐ Yes ☐ No Sargenti, RC-2B, N2
☐ Yes ☐ No Myomonitor
☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Laser (Excluding curing composites and whitening. If "Yes" please describe the type of laser used and procedures that are performed on a separate sheet of paper.)
☐ Yes ☐ No Botox Injections (other than treating facial spasms, TMJ pain dysfunction and muscular pain)

9. Please indicate below if you currently perform any surgical procedures.
If "Yes" please estimate the percentage each surgical procedure bears to your total practice on an annual basis.

Surgical Procedure / Treatment			Estimated % of Total Practice per Year
☐ Yes	☐ No	TMJ – Surgical	_____
☐ Yes	☐ No	Implants – Surgical Placement	_____
☐ Yes	☐ No	Extraction of Third Molars	_____
☐ Yes	☐ No	Periodontal - Surgical Procedures	_____
☐ Yes	☐ No	Cosmetic – Elective surgical and/or Full Mouth Reconstruction (please describe on separate sheet of paper)	_____
☐ Yes	☐ No	Other Surgery (describe): _____	_____

E. OFFICE PROCEDURES

1. Please confirm your average number of patients per week _____, and average number of Practice hours per week _____.

Informed Consent

2. What type of informed consent do you use? ☐ Oral ☐ Written ☐ None

3. If oral, is chart noted, dated and initialed by the patient? ..... ☐ Yes ☐ No

Medical History

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

5. How often do you or your staff update patient histories? ☐ Each visit ☐ Occasionally ☐ No policy

If occasionally, what is your procedure? _____

6. Please attach a copy of your practice letterhead to this application.

F. ANESTHETICS AND ANALGESIA

Please describe your use of anesthetics and types of analgesia in your practice as indicated below.
For purposes of this application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.

1. Is your practice limited to the use of local anesthesia and/or oral conscious medication? ..... ☐ Yes ☐ No

2. Are you treating patients under IV conscious sedation? ..... ☐ Yes ☐ No

3. Are you treating patients who are under general anesthesia (deep sedation)? ..... ☐ Yes ☐ No

If you answered "Yes" to either question 2 or 3, please indicate below the type of agents used for each "Yes" answer, the frequency of use, where (office, hospital, medical center) the anesthesia is administered, and by whom (yourself, MD Anesthetist, RN Anesthetist or other).

AGENTS	FREQUENCY	LOCATION	ADMINISTERED BY
AGENTS	FREQUENCY	LOCATION	ADMINISTERED BY

G. OTHER EXPOSURE INFORMATION

1. Do you own or operate a dental laboratory? ..... ☐ Yes ☐ No
If "Yes", please estimate percentage of work applicable to your own patients_____%

2. Do you own or operate any other business enterprise? .... ☐ Yes ☐ No
If "Yes", please describe:

_____

_____

_____

3. Have you signed any contractual agreements where you have agreed to provide services to others? ..... ☐ Yes ☐ No

Please identify parties to the contract and describe services:

_____

_____

4. Have you agreed to hold any other party harmless for services you perform? ..... ☐ Yes ☐ No

5. Please identify any additional insureds requested to be named on the policy applied for:

_____
LESSOR OF LEASED PREMISES:

_____
LESSOR OF LEASED EQUIPMENT:

_____
OWNER OF PREDECESSOR PRACTICE:

_____
OTHER, PLEASE EXPLAIN:

H. CLAIMS AND EXPERIENCE INFORMATION

If you answer "Yes" to questions 1, 2 or 3 below, please provide on your letterhead the information requested below for each claim.

(a) Claimant's Name,
(b) Date of Alleged Error,
(c) Name of Insurer,
(d) If claim is closed, the total amount paid,
(e) If claim is pending, the claimant's demand amount and insurer's loss reserve,
(f) Description of claim including alleged error according to the claimant and your description of your treatment and extent of injury sustained.

1. Has any claim been made against you alleging dental malpractice? ☐ Yes ☐ No

2. Do you know of any facts, circumstances, injuries, damages, acts, errors or omissions which may result in a malpractice claim against you, other dentists employed by you or your auxiliary staff? ☐ Yes ☐ No

If "Yes", have these been reported to a professional liability insurer? ☐ Yes ☐ No

3. Have you ever utilized Peer Review in an attempt to settle a patient complaint? ☐ Yes ☐ No

4. Please answer the following. For any "Yes" answers, please explain on your letterhead.

a. Have you ever had any restriction, suspension, probation or revocation of a license to practice dentistry? ☐ Yes ☐ No

b. Have you ever had any restriction, suspension, probation or revocation of a license to administer or prescribe drugs? ☐ Yes ☐ No

c. Have you ever had any restriction, suspension, probation or revocation of privileges in any hospital or other health care facility? ☐ Yes ☐ No

d. Have you ever had any personal health problems (including alcoholism, drug addiction, mental illness or communicable disease)? ☐ Yes ☐ No

e. Have you ever had complaints filed against you involving the administration of Medicare/Medicaid or patient insurance? ☐ Yes ☐ No

f. Have you ever been declined, canceled or non-renewed for any Dental Professional Liability Insurance? ☐ Yes ☐ No
Missouri Residents: Do Not Respond

g. Other than traffic violations, have you ever been convicted of a crime? ☐ Yes ☐ No

5. If you are applying for Business Liability Coverage in addition to Professional Liability Coverage, please answer the following questions. Have any claims been made against you in the last five years arising out of:

a. liability for your office premises including damages from water or fire to leased premises? ☐ Yes ☐ No

b. liability arising out of the use of automobiles not owned by you? ☐ Yes ☐ No

c. claims for benefits for your employees arising out of your administration of those benefits? ☐ Yes ☐ No

d. allegations of sexual harassment, unfair discrimination or other wrongful employment practices? ☐ Yes ☐ No

e. violation of any rule or law regulating the disposal of medical wastes? ☐ Yes ☐ No

NOTICE TO APPLICANT: PLEASE READ CAREFULLY

CLAIMS MADE POLICIES ONLY: I understand that my Dentist's Liability coverage is written on a "Claims-Made form" and acknowledge that this coverage will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-made" coverage will not provide insurance coverage for claims which occurred prior to the Retroactive Date of my policy.

I understand that, should my "Claims-Made" policy with this insurance carrier ever be canceled or nonrenewed, or I decide to terminate it for any reason, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy but were not reported to the insurance company before the date of the policy termination, I will have sixty (60) days in which to purchase a Reporting Endorsement. Such Reporting Endorsement is required to provide coverage for claims reported to the insurance company after the termination date, but which are based on dentistry performed during the active policy period.

OCCURRENCE POLICIES ONLY: I understand that my Dentist's Liability coverage is written on an "Occurrence form" and acknowledge that this coverage will only respond to claims for acts, errors or omissions that take place after the policy effective date and before the policy expiration date regardless of when the claims are reported.

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

FRAUD WARNING NOTICE

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. In New York, such person 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.

FAIR CREDIT REPORTING ACT

This notice is given to comply with the Federal Fair Credit Reporting Act (Public Law 91-509) and any similar state law which is applicable. As part of our underwriting procedure, a routine inquiry may be made which will provide information concerning character, general reputation, personal characteristics and mode of living.

I understand any policy issued will rely on the truth of the statements and representations I have made herein and that false or misleading statements or misstatement or misrepresentations may result in a denial of coverage for any claim which may be made under the insurance for which application is made hereunder.

I hereby authorize and direct any person or organization to release and furnish to the Insurance Company any and all information requested which may relate to my insurability under the Dentist's Advantage Professional Liability Policy.

X _____

APPLICANT'S SIGNATURE **DATE**

Application is made to one of the Fireman's Fund Insurance Companies. This program is only available within the United States. Coverages, rates and limits differ in some states. Availability of this program is subject to each state's approval.

Dentist's Advantage is a division of Affinity Insurance Services, Inc.; in NY and NH, AIS Affinity Insurance Agency; in MN and OK, AIS Affinity Insurance Agency, Inc.; and in CA, AIS Affinity Insurance Agency, Inc. dba Aon Direct Insurance Administrators License #0795465.

Affinity Insurance Services, Inc. 159 East County Line Road, Hatboro, PA 19040-1218
866-219-6533

Dentist's Advantage

DENTIST SUPPLEMENTAL APPLICATION

INSURED NAME _____ POLICY EFFECTIVE DATE _____

1. WHICH OF THE FOLLOWING TMJ THERAPY DO YOU PERFORM IN YOUR OFFICE? _____ NONE

   (CHECK ANY THAT APPLY)

   _____ INITIAL EXAMINATION
   _____ COMPREHENSIVE TMJ THERAPY
   _____ TMJ SURGERY
   _____ TMJ DISORDER REFERRALS
   _____ TMJ RADIOGRAPHY
   _____ BITE GUARD/SPLINTS
   _____ TMJ DISORDER PALLIATIVE THERAPY

2 WHICH OF THE FOLLOWING ENDODONTIC PROCEDURES DO YOU PERFORM?

   (CHECK ANY THAT APPLY)
   _____ ALL ENDODONTICS REFERRED
   _____ "CONVENTIONAL" GUTTA PERCHA
   _____ THERMAFIL OR THERMAFIL-LIKE
   _____ SARGENTI OR SARGENTI-LIKE
   _____ APICOECTOMIES

3 WHICH OF THE FOLLOWING TOOTH REPLACEMENT IMPLANT PROCEDURES DO YOU PERFORM?

   (CHECK ANY THAT APPLY)

   _____ SURGICAL PLACEMENT OF IMPLANTS
   _____ REFERRAL FOR IMPLANT THERAPY
   _____ RESTORATION OF IMPLANTS
   _____ NONE

4 WHICH OF THE FOLLOWING SURGICAL PROCEDURES DO YOU PERFORM? (CHECK ANY THAT APPLY)

   _____ NONE
   _____ FULL MOUTH RESTORATIONS
   _____ MAJOR PERIODONTAL SURGERY
   _____ BIOPSIES, OTHER THAN BRUSH BIOPSIES
   _____ BONEY IMPACTED THIRD MOLARS EXTRACTIONS

5 DO YOU UTILIZE ANY OF THE FOLLOWING PIECES OF DENTAL EQUIPMENT IN YOUR PRACTICE?

   (CHECK ANY THAT APPLY)
   _____ NONE
   _____ DENTAL LASER
   _____ LOUPES OR OTHER MAGNIFIERS
   _____ DIGITAL RADIOGRAPHY
   _____ INTRAORAL CAMERA

6. PLEASE INDICATE YOUR EMPLOYMENT STATUS FOR THE PRACTICE OF DENTISTRY (CHECK ANY THAT APPLY)

   _____ EMPLOYEE
   _____ SELF EMPLOYED
   _____ INDEPENDENT CONTRACTOR
   _____ PARTNER
   _____ PROFESSIONAL CORPORATION

7. IF YOU ARE AN EMPLOYER:

   HOW MANY EMPLOYEES DENTISTS WORK FOR YOU? _____

   HOW MANY INDEPENDENT CONTRACTORS WORK FOR YOU? _____

   IS IT YOUR POLICY THAT PATIENTS ARE ALWAYS TREATED BY THE SAME DENTIST?_____

_____ _____

SIGNATURE DATE