



# Application for Coverage Professional & Business Liability Insurance

## 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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Desired Retroactive Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

1.

NAME

Professional Degree  DDS  DMD  OTHER Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PRIMARY PRACTICE LOCATION (SEE QUESTION 3 FOR ADDITIONAL PRACTICE LOCATIONS)

MAILING ADDRESS, IF DIFFERENT FROM PRACTICE ADDRESS

Do you own your own practice?  Yes  No

NUMBER OF LOCATIONS WHERE YOU PRACTICE  Owner  Tenant

If **owner**, is your property policy with TDIC?  Yes  No

If **no**, name of carrier

Do you work as an employee or independent contractor?  Yes  No

TAX ID NO. /SSN

E-MAIL ADDRESS

OFFICE PHONE NO.

OFFICE FAX NO.

ALTERNATE PHONE NO.

FAX NO.

DENTAL LICENSE NO.

STATE

EXP. DATE

DENTAL SCHOOL

YEAR GRADUATED

YEAR FIRST BEGAN PRACTICE IN U.S.

Do you hold a dental license in other states?  Yes  No

If **yes**, list the states in which you hold a dental license.

2. TYPE OF PRACTICE

a.  General Dentistry

Have you completed a General Practice Residency Program?  Yes  No

\_\_\_\_\_  
NAME OF HOSPITAL

\_\_\_\_\_  
YEAR COMPLETED

Specialty

\_\_\_\_\_  
SPECIALTY

\_\_\_\_\_  
SPECIALTY NO.

\_\_\_\_\_  
SPECIALTY SCHOOL ATTENDED

\_\_\_\_\_  
YEAR SPECIALTY TRAINING COMPLETED

Do you perform cosmetic surgery or liposuction?  Yes  No

\_\_\_\_\_  
WHAT TYPES OF PROCEDURES DO YOU PERFORM (RHINOPLASTY, GENIOPLASTY, COLLAGEN INJECTIONS, OTHER)?

Do you perform these as elective or non-elective procedures?  Elective  Non-elective  
*(Non-elective procedures are directly related to and part of treatment for dental conditions.)*

b. 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.

\_\_\_\_\_  
HOURS PER WEEK

\_\_\_\_\_  
NAME OF SCHOOL

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

If **yes**, you must attach a letter from the school verifying your full-time student status to receive the postgraduate discount.

d. As which of the following do you provide professional services?

Owner  Associate, Employee or Independent Contractor  Partner or Shareholder

If other, please explain below:

\_\_\_\_\_

e. If you practice less than 21 hours per week on average:

\_\_\_\_\_  
HOW MANY HOURS PER WEEK DO YOU SPEND PRACTICING THE PROFESSION OF DENTISTRY?

\_\_\_\_\_  
HOW LONG HAVE YOU MAINTAINED THIS SCHEDULE?

\_\_\_\_\_  
HOW LONG DO YOU EXPECT TO MAINTAIN THIS SCHEDULE?

\_\_\_\_\_  
HOW MANY EMPLOYEES DO YOU HAVE?

\_\_\_\_\_  
LIST THE DAYS OF THE WEEK YOU NORMALLY WORK.

f. 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. For each of your practice location(s), please provide a list of the names of dentists present at that location, including dentists who only perform hygiene procedures, and your business relationship with each dentist (i.e., employee, employer, independent contractor, associate, partner or shareholder). Our underwriting guidelines require confirmation of professional liability insurance for dentists who work with you. Please provide the name of each dentist's insurance carrier. **We only insure dentists who work with insured dentists.** Please use additional sheets if necessary.

Not applicable (no other dentist present)

LOCATION	INTEREST	NAME	ADDRESS	BUSINESS RELATIONSHIP TO YOU (SEE ABOVE)	NAME OF PROFESSIONAL LIABILITY CARRIER
	<input type="checkbox"/> Owner <input type="checkbox"/> Tenant				
	<input type="checkbox"/> Owner <input type="checkbox"/> Tenant				
	<input type="checkbox"/> Owner <input type="checkbox"/> Tenant				
	<input type="checkbox"/> Owner <input type="checkbox"/> Tenant				
	<input type="checkbox"/> Owner <input type="checkbox"/> Tenant				

4. STATE DENTAL ASSOCIATION OR SOCIETY

a. Are you a member of your state dental association or society?  Yes  No

b. If **no**, are you an applicant to your state dental association or society?  Yes  No

ADA NO.

LOCAL DENTAL SOCIETY

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

INSURANCE CO.	CERTIFICATE/POLICY NO.	NO. POLICY YEAR(S)	TYPE OF POLICY <small>(O=OCCURRENCE/CM=CLAIMS MADE)</small>

*Attach a copy of your last declarations page(s), including your prior acts or retroactive date.*

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

*If yes, please give details.*

7. Has any insurer ever cancelled, declined or modified coverage (i.e., reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal of your professional liability insurance?  Yes  No

*If yes, please give details.*



8. Do you treat patients under any of the anesthetic modalities listed below? \_\_\_\_\_  
STATE PERMIT NO.

- None  Local anesthesia  N<sub>2</sub>O/O<sub>2</sub> analgesia  Oral conscious sedation
- Conscious sedation (including IM or IV) in hospital or surgi-center, administered by dentist anesthesiologist, M.D. anesthesiologist or oral and maxillofacial surgeon.
- Conscious sedation (including IM or IV) in office.

\_\_\_\_\_  
WHO ADMINISTERS THIS ANESTHESIA?                      NAME OF CARRIER                      STATE PERMIT NO.

- General anesthesia in hospital or surgi-center, administered by dentist anesthesiologist, M.D. anesthesiologist or oral and maxillofacial surgeon.
- General anesthesia in office

\_\_\_\_\_  
WHO ADMINISTERS THIS ANESTHESIA?                      NAME OF CARRIER                      STATE PERMIT NO.

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

If **oral**, is chart noted and dated?  Yes  No

10. If you perform oral surgery, do you obtain a documented patient consent prior to performing the surgery?  
 Yes  No

11. Do you perform procedures using dental implants?  Yes  No

If **yes**: Do you perform the surgical placement of the implant?  Yes  No  
Do you perform the prosthetic or restorative component?  Yes  No

12. Do you use filling material or sealer containing paraformaldehyde or Sargenti pastes?  Yes  No

13. a. Does your practice include spa dentistry?  Yes  No

\_\_\_\_\_  
*If yes, what types of services are provided?*

b. Do you request proof of insurance coverage from anyone who provides these services for your office?  
 Yes  No

14. Is botulinum toxin (i.e., Botox®) used in your practice?  Yes  No

\_\_\_\_\_  
*If yes, for what procedures?*

15. Are derma fillers (i.e., Restylane®) used in your practice?  Yes  No

\_\_\_\_\_  
*If yes, for what procedures?*

16. What percentage of third molar extractions do you refer? \_\_\_\_\_

17. What percentage of your practice is cosmetic dentistry? \_\_\_\_\_



18. Do you perform sleep apnea/snoring therapy?  Yes  No  
If **yes**, do you treat after a physician's referral?  Yes  No

19. How often are health histories updated? \_\_\_\_\_

20. DESIRED LIMIT OF LIABILITY

*Check one only*

- \$500,000 per occurrence/\$1,500,000 aggregate per policy year – Option code 08  
 \$1,000,000 per occurrence/\$3,000,000 aggregate per policy year – Option code 07  
 \$1,500,000 per occurrence/\$4,500,000 aggregate per policy year – Option code 09  
 \$3,000,000 per occurrence/\$3,000,000 aggregate per policy year – Option code 11  
 \$5,000,000 per occurrence/\$5,000,000 aggregate per policy year – Option code 06

21. Are you part of a partnership or corporation?  Yes  No

Name of corporation or partnership \_\_\_\_\_

22. Identity Recovery Coverage for the individual is included with the Professional & Business Liability policy.  
Family members can be added for an additional charge.

Type of Identity Recovery Coverage desired?  Individual  Family

23. 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.*

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

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

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

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

26. 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.*

27. Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked?  Yes  No

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

28. 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.*



29. 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. Please type or print legibly.

\_\_\_\_\_  
 YOUR NAME

\_\_\_\_\_  
 NAME OF PATIENT/CLAIMANT

\_\_\_\_\_  
 CITY, COUNTY, AND STATE WHERE INCIDENT OCCURRED

\_\_\_\_\_  
 DATE(S) OF ALLEGED OCCURRENCE

\_\_\_\_\_  
 ALLEGATION

Were you insured?  Yes  No

\_\_\_\_\_  
 If **yes**, list the name of your insurer.

\_\_\_\_\_  
 DATE INCIDENT/CLAIM/SUIT REPORTED TO INSURANCE COMPANY

\_\_\_\_\_  
 CURRENT DISPOSITION

\$ \_\_\_\_\_ \$ \_\_\_\_\_ / /  
 If open, amount of reserve If closed, amount of total settlement or judgment Date closed

\$ \_\_\_\_\_  
 AMOUNT PAID ON YOUR BEHALF

If no payment was made, how was the matter concluded?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please provide a narrative description of the claim or allegations, including nature of treatment, your involvement, etc. (Please attach additional sheets as needed.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





## Employment Practices Liability Insurance

Desired Limit of Liability (check one)    \$50,000    \$100,000

1. Number of employees by location(s), excluding family members:

	LOCATION 1		LOCATION 2	
	FULL TIME	PART TIME	FULL TIME	PART TIME
Hygienists				
Dental Assistants				
Partners or Shareholders				
Other Office Staff				
<b>TOTAL</b>				

2. List by name and job title all independent contractors who work at each practice location:  
(List on a separate sheet if additional space needed.)

_____	_____	_____
NAME	TITLE	LOCATION
_____	_____	_____
NAME	TITLE	LOCATION
_____	_____	_____
NAME	TITLE	LOCATION

3. Give the full name of each employee dentist and indicate whether he/she is working under a contract that gives him/her the right to take over the practice.

_____	Contract?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	
	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Have you terminated an employee or independent contractor within the past five (5) years?    Yes    No

*If yes, please give the date and reason for the termination.*

5. Have you 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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6. Other than disclosed in questions 4 and 5, have you had any employment-related claims, allegations or incidents within the past two (2) years?  Yes  No

*If yes, please list by name and describe all employment-related claims, allegations or incidents you have experienced within the past two (2) years. Include any settlement amount or final determination amount of the claim(s) and the date. Example: wrongful termination or discrimination.*

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7. In your office, do you have written procedures in place with regard to the following:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Termination   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hiring  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Discipline  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a standard employment application for all applicants?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have an employment handbook?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have an "At Will" provision in the employment application or handbook?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a written policy with respect to sexual harassment?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a written policy with respect to discrimination?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have written annual performance evaluations for employees?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If <b>yes</b> , are the evaluation documents in writing and signed by the employees?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have written procedures for handling employee complaints regarding harassment or discrimination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you post the required federal and state regulations?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please describe how employees are notified of the above procedures:

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Please explain all **no** responses:

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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.

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.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

**Return this application by mail or fax.**

**MAIL TO:** The Dentists Insurance Company  
P.O. Box 1582  
Sacramento, CA 95812-1582

**FAX TO:** 916.498.6105

**Questions? Call your local broker:**

Alaska – 907.276.7667, Conrad-Houston Insurance

California – 800.733.0633, TDIC Insurance Solutions

Georgia – 404.636.7553, GDIS

Hawaii – 808.521.1841, Jerry Hay, Inc.

Illinois – 866.TDIC.4.US or 866.834.2487, RH Insurance

Minnesota – 877.245.1070, TDIC Insurance Solutions

Nevada – 888.319.7477, NDAIA

New Jersey – 877.476.4588, Mid-Atlantic Insurance Resources

New Mexico – 505.822.8114 or 800.422.8925, New Mexico Dental Benefits

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.

**New Mexico Professional & Business Liability Application** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal 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.