

**Dental Professional Liability Insurance Application - Individual Dentist**

With your fully completed, signed and dated application, you must submit the following information:

1. Current insurance policy declarations page.
2. Copy of extended reporting endorsement (tail) from your current carrier if your current coverage is claims-made and you are *not* applying for Prior Acts Coverage.
3. Loss runs from all prior insurance companies or explanation as to why they are not available.
4. Current business letterhead.

**1. Personal Information**

---

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Gender: Male  Female

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Dental License Number(s):	State	License Number	Expiration Date	% of Practice
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List all State and County Dental Associations you currently belong to: \_\_\_\_\_

**2. Practice Location**

---

Practice Name: \_\_\_\_\_

Practice Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Kentucky Only: Professional office located within the city limits of: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Website: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Email Address: \_\_\_\_\_

**Please list other practice locations:**

Practice Name: \_\_\_\_\_

Practice Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Dates: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Percent of Practice: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Dates: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Percent of Practice: \_\_\_\_\_



D. Anesthesia/Sedation

1. Check the type of anesthesia and/or sedation used in your practice and number of procedures done per year in an office or hospital practice, and who administers the anesthesia/sedation.

Local and/or Nitrous Oxide Only  
In Office \_\_\_\_\_ In Hospital \_\_\_\_\_

Who Administers: \_\_\_\_\_

Oral Moderate Sedation  
In Office \_\_\_\_\_ In Hospital \_\_\_\_\_

Who Administers: \_\_\_\_\_

IV/IM Moderate Sedation  
In Office \_\_\_\_\_ In Hospital \_\_\_\_\_

Who Administers: \_\_\_\_\_

General Anesthesia  
In Office \_\_\_\_\_ In Hospital \_\_\_\_\_

Who Administers: \_\_\_\_\_

\*Please note: If you checked IV/IM sedation, oral moderate sedation, or general anesthesia, we may require a supplemental application to be completed.

2. Please indicate your certification information:

ACLS     BCLS     PALS

3. Do you require that your staff be certified (ACLS, BCLS, or PALS)?

Yes  No

E. Do you teach in a dental school?

Yes  No

If yes, indicate how many hours per week and if coverage is provided through the dental school in the space provided at the end of the application.

F. Do you treat or review treatment of inmates in a correctional institution?

Yes  No

If yes, list the correctional institution, percent of your total practice time, and if coverage is provided through the facility in the space provided at the end of the application.

G. Do you treat patients via a mobile dental unit?

Yes  No

If yes, please list percent of your total practice time: \_\_\_\_\_%

H. Do you treat or review treatment of patients in a nursing home facility?

Yes  No

If yes, please list percent of your total practice time: \_\_\_\_\_%

I. Do you treat sleep apnea patients?

Yes  No

If yes, do you ever treat without a physician referral?

Yes  No

J. Do you perform any procedures that are clinical trials, experimental, not usual or customary to the specialty or that are not approved by the ADA or the FDA?

Yes  No

If yes, describe in the space provided at the end of the application.

K. Do you provide elective facial cosmetic procedures, Botox, collagen injections, or other dermal fillers for cosmetic purposes in your practice?

Yes  No

L. Do you perform procedures outside the oral and maxillofacial region?

Yes  No

If yes, describe procedures and number provided per year in the space provided at the end of the application.

M. Do you provide forensics or expert witness testimony?

Yes  No

7. Insurance History and Claim Information

A. Current Insurance Information:

i. Name of Insurer: \_\_\_\_\_

ii. State Where Practiced: \_\_\_\_\_

iii. Policy Limits: \_\_\_\_\_

iv. Dates Covered, From: \_\_\_\_\_ To: \_\_\_\_\_

v. Policy Type: Claims-Made  Occurrence

vi. If Claims-Made, Retro Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)?

Yes  No

B. Previous Insurance Information:

i. Name of Insurer: \_\_\_\_\_

ii. State Where Practiced: \_\_\_\_\_

iii. Policy Limits: \_\_\_\_\_

iv. Dates Covered, From: \_\_\_\_\_ To: \_\_\_\_\_

v. Policy Type: Claims-Made  Occurrence

vi. If Claims-Made, Retro Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes  No

C. Previous Insurance Information:

i. Name of Insurer: \_\_\_\_\_

ii. State Where Practiced: \_\_\_\_\_

iii. Policy Limits: \_\_\_\_\_

iv. Dates Covered, From: \_\_\_\_\_ To: \_\_\_\_\_

v. Policy Type: Claims-Made  Occurrence

vi. If Claims-Made, Retro Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes  No

D. Will you be carrying additional liability insurance with another company? Yes  No

If yes, provide name of company, limits, expiration date, and services covered in the space provided at the end of the application.

If you answer yes to questions E, F, or G, including any sub-questions, please complete the attached Supplementary Claims Information Form.

E. Have you ever been involved in a dental professional liability claim or suit? The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership. Yes  No

F. Other than the situations indicated in 7.E. above, are you aware of any of the following circumstances:

i. A request for records from a patient, family member, attorney, or patient representative related to an adverse outcome or treatment of a patient? Yes  No

ii. A letter from an attorney regarding your treatment of a patient? Yes  No

iii. A patient, family member, or patient representative's dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes  No

iv. Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes  No

G. Have all circumstances in question 7.F. above been reported to your current or prior professional liability carrier? Yes  No  N/A\*

If yes, how many? \_\_\_\_\_ Please attach documentation of all such reports.

If no, please explain in space provided at the end of the application.

\*For purposes of this question, N/A means that you answered "No" to each subpart of question 7.F.

H. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? This question is not applicable in Missouri. Yes  No

8. Personal History

(If you answer yes to any of the following questions, provide complete details in the space provided at the end of the application or on a separate sheet.)

A. Have you ever been treated for alcoholism, drug addiction, sexual addiction, or mental illness? Yes  No

B. Are you aware of, or in a treatment program for, any health impairment or disability that may affect your ability to perform professionally? Yes  No

C. Have you ever been convicted of, pled guilty to, or pled no contest to a felony? Yes  No

D. Have you ever been convicted of, pled guilty to, or pled no contest to a violation of any law or ordinance (other than minor traffic offenses), including driving while under the influence of alcohol or any other substance? Yes  No

E. Have you ever failed any licensing or Board Certification examinations? Yes  No

F. Has your license to practice dentistry or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? Yes  No

G. Have you ever appeared before, been investigated by, or entered into any consent agreement with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes  No

- H. Have you ever had a patient or patient representative complain to or file a grievance of any type with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes  No
- I. Have you ever voluntarily surrendered your hospital privileges, narcotics or professional license to avoid suspension, restriction, probation, or revocation? Yes  No
- J. Has any hospital ever restricted, suspended, revoked, or refused your privileges or has probation ever been invoked? Yes  No
- K. Have you ever been accused of sexual misconduct or inappropriate physical contact? Yes  No

**GENERAL FRAUD WARNING – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage.

**For Agent's Use Only (if applicable)**

\_\_\_\_\_  
Agent's Name

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Agency Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

## Additional Comments

**Dentist's Supplementary Claims Information Form**

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

- 1. Patient's Name: \_\_\_\_\_
- 2. Date Reported to Insurance Company: \_\_\_\_\_
- 3. Name of Insurance Company: \_\_\_\_\_
- 4. Name and Address of the Attorney Assigned to Your Case: \_\_\_\_\_
- 5. Date of Incident and Your Treatment: \_\_\_\_\_
- 6. Allegations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. What is the present condition of the patient? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes  No

9. Status of claim (check applicable answer):

- Suit threatened, no action taken
- Suit filed, but dropped by claimant
- Summary Judgment in your favor
- Suit settled Out-of-Court  
Date claim paid: \_\_\_\_\_  
Amount paid: \_\_\_\_\_

- Court outcome in your favor
  - Jury verdict
  - Directed verdict
- Court outcome in favor of plaintiff
  - Jury verdict
  - Directed verdict
- Amount of Loss: \_\_\_\_\_

- Awaiting mediation
- Awaiting court action
- Reserve Amount: \_\_\_\_\_

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes  No   
If yes, amount was: \$ \_\_\_\_\_

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_