



The Professional Protector Plan® Professional & General Liability Insurance for Dentists

Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A. Application must be signed and dated by applicant.

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued.

Requested Effective Date: _____ / _____ / _____ New Policy Rewrite of Policy Number: _____

PLEASE TELL US ABOUT YOURSELF

1. Full Name: _____ DDS DMD MD BDS MS

2. Mailing Address: _____
City / State / Zip: _____

3. E-mail Address: _____ 4. Website: _____

5. Would you would like the PPP's quarterly Risk Management Newsletter sent via email? Yes No

6. Telephone Number: (_____) _____ 7. Fax Number: (_____) _____

8. All Dental Schools Attended: _____ 9. Month / Year of Graduation: _____

10. Did you complete a residency?..... Yes No
If "Yes", Specialty: _____ Month / Year of Completion: _____

11. Are you entering practice for the first time?..... Yes No

12. Have you ever practiced dentistry outside of the United States and / or its territories?..... Yes No
If "Yes", please explain: _____

13. Date of Birth: _____ 14. Years in Practice: _____

15. How many hours per week do you practice (include administrative duties, record keeping, lab work, patient visitation and consultation)? _____ **
**If 20 hours or less, please complete a Part-time Supplement provided by your agent.

16. Under which business structure do you practice?
 Sole Proprietor Limited Liability Company Limited Liability Partnership Incorporated Partnership
 Employee Dentist Independent Contractor Faculty (**Occurrence** coverage only) Volunteer (**Occurrence** coverage only)

If applicable, please list name of Employer / Facility: _____

If you volunteer, please describe volunteer services provided: _____

If you volunteer, will you receive remuneration for your volunteer services? Yes No

17. Practice addresses and percentage of practice at each address (total of percentages must equal 100%):

| | | | | | | |
|--------------------|--------------|------------|--------------|-------------|----------------|---|
| A. Primary: | Street _____ | City _____ | County _____ | State _____ | Zip Code _____ | % |
| B. | Street _____ | City _____ | County _____ | State _____ | Zip Code _____ | % |
| C. | Street _____ | City _____ | County _____ | State _____ | Zip Code _____ | % |

18. Indicate your Practice Specialty (please check all that apply):

General Dentistry Dental Radiologist Periodontics Oral / Maxillofacial Surgery Dental Anesthesiologist
 Endodontics Oral Radiology Prosthodontics Pediatric Dentistry Full-time Faculty-Non-Intramural

Orthodontics Public Health Oral Pathology Other - describe: _____

PLEASE TELL US ABOUT YOUR PROFESSIONAL LIABILITY COVERAGE NEEDS

19. Select the Professional Liability coverage type and limits desired. All limits may not be available in all states (select either Claims-Made or Occurrence):
 PLEASE CONTACT YOUR AGENT IF HAVE ANY QUESTIONS REGARDING THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE
 AS WELL AS FOR DETAILED INFORMATION REGARDING AN EXTENDED REPORTING PERIOD AS IT RELATES TO CLAIMS-MADE COVERAGE.

- Claims-Made Coverage****
 \$1,000,000 / \$3,000,000 \$2,000,000 / \$3,000,000 \$2,000,000 / \$4,000,000 \$2,000,000 / \$6,000,000 \$3,000,000 / \$3,000,000
 \$3,000,000 / \$6,000,000 \$4,000,000 / \$4,000,000 \$5,000,000 / \$5,000,000 \$5,000,000 / \$6,000,000 \$5,000,000 / \$8,000,000
 Other _____
 (STATE EXCEPTIONS MAY APPLY)

**THIS IS AN APPLICATION FOR CLAIMS-MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

- Occurrence Coverage**
 \$1,000,000 / \$3,000,000 \$2,000,000 / \$2,000,000 \$2,000,000 / \$6,000,000 Other _____
 (STATE EXCEPTIONS MAY APPLY)

20. If Claims-Made Coverage is desired, please complete the following:

- A. Are you applying for prior acts coverage from AAIC?** Yes No
- B. Retroactive Date / Prior Acts Date on your current Claims-Made policy**:** ____/____/____
 **If prior acts is desired, please attach a copy of your last declaration page (face sheet)
- C. Was an Extended Reporting Endorsement (tail) purchased from your previous carrier?** Yes No

PLEASE TELL US ABOUT YOUR GENERAL LIABILITY NEEDS

21. Do you desire shared or separate limits of liability to apply to each location (limits will be equal to your professional liability limits):

- Shared (Limits are Shared with each location at no additional cost) Separate (each location has its own set of limits and an additional charge applies)

22. Have you had any general liability losses in the past 3 years? (If "Yes", please provide a summary of the loss and claim amount) Yes No

23. Do you desire to increase your limit of liability for ERISA Fiduciary Liability Coverage / Employee Benefits Liability above the included \$25,000? Yes No

Coverage is recommended if you sponsor an Employee Benefit Plan. This is NOT the bond for your pension plan. Coverage is written on a Claims-Made basis.

- If "Yes", check the desired limit of liability: \$100,000 \$250,000 \$500,000 \$750,000 \$1,000,000

24. If you are a TENANT, would you like to increase the standard \$500,000 Fire / Water Legal Liability Limit? Yes No

- If "Yes", check the desired limit of liability: \$750,000 \$1,000,000

25. If you have an equipment lease, building lease, rental agreement, etc. that requires you to name an entity as an additional insured for general liability purposes, please provide the name and address of the entity as it appears in your contract/agreement:

PLEASE TELL US ABOUT YOUR OTHER LIABILITY NEEDS

26. Standard Employment Practices Liability Defense Coverage Only; limits: \$25,000 Each Claim, \$25,000 Annual Aggregate (coverage is automatically provided unless a STATE EXCEPTION APPLIES).

- Do you wish to amend the standard coverage type from Defense Only to Indemnity and Defense (an additional charge will apply)? Yes No
 If "Yes", please complete the **Employment Practices Liability Indemnity Supplemental Application** provided by your agent.

27. Standard Cyber Liability Coverage (coverage and limits outlined below are automatically provided at no charge unless a STATE EXCEPTION APPLIES):

| Coverage | Limit Per Occurrence | Aggregate Limit | Total Aggregate Limit | Deductible |
|---|----------------------|-----------------|-----------------------|---|
| Network Extortion | \$5,000 | \$50,000 | \$150,000 | \$1,000 deductible applies to all coverages except Privacy Event Expense. |
| First Party Loss | \$100,000 | \$100,000 | | |
| Privacy Event Expense | \$5,000 | \$5,000 | | |
| Regulatory Investigations | \$50,000 | \$100,000 | | |
| Privacy Regulatory Proceedings, Network Security and Privacy Injury | \$50,000 | \$150,000 | | |

- Do you wish to increase the Cyber Liability aggregate limit to \$1,000,000 (an additional charge will apply)? Yes No
 If "Yes", please complete the **Supplemental Application for Information Risk Coverage** provided by your agent.

PLEASE TELL US ABOUT THE PROCEDURES PERFORMED IN YOUR PRACTICE

28. Which of the following procedures are performed by you?

- Sleep Apnea Therapy or Fabrication of Snore Guards Only

If **Sleep Apnea Therapy** is more than snore guards, please indicate the following:

I treat only after referral from physician Yes No

I treat without physician referral Yes No If "**Yes**", please provide a written explanation.

- IRREVERSIBLE** TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)

- Implant Placement/Uncovering/Surgery
- Partially Impacted Third Molar Extractions
- Fully Impacted Third Molar Extractions
- Molar Endodontics on Permanent Teeth
- Mini-Implants
- Conscious Sedation
- None of these

- Informed Consent Type**
- Written Oral Both
 - Written Oral Both
 - Written Oral Both
 - Written Oral Both
 - Written Oral Both
 - Written Oral Both

- Training**
- CE Dental School Post Grad None
 - CE Dental School Post Grad None
 - CE Dental School Post Grad None
 - CE Dental School Post Grad None
 - CE Dental School Post Grad None
 - CE Dental School Post Grad None

A. Have you discontinued any procedures listed above in the last five years?

Yes No

Which procedures? _____

29. Do you or someone under your supervision/direction perform elective cosmetic dermal procedures (including but not limited to Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.)? _____

Yes No

If "**Yes**", please provide an explanation on a separate sheet of paper.

30. Are you treating patients who are under general anesthesia / deep sedation (A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposely to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof)?

Yes No

If "**Yes**", where is the treatment provided?

Your office

Hospital or licensed / regulated surgical center

If administered in **your office**, who administers the anesthesia?

Yourself

Another Dentist, Anesthesiologist, or CRNA **

** Please provide proof of current Professional Liability coverage

PLEASE TELL US ABOUT YOUR PARTICIPATION

31. Are you a member of your state dental association or society?

Yes No

If "**Yes**", provide name of association / society: _____

32. Have you taken one of the following risk management seminars in the last 3 years?

Yes No

If "**Yes**", please indicate which one and provide evidence of attendance:

PPP (Evidence not required if you are a PPP insured) Date of Attendance: _____ / _____ / _____

AAOMS / OMSNIC AAO NYSDA / DSSNY Henry Spenadel CNA

PLEASE TELL US ABOUT YOUR LICENSE HISTORY

33. List all states where you hold, or have held, a Dental License even if the license is not currently active (attach a separate sheet if needed):

| State | License Number | Status of License (e.g., active, inactive, pending, etc.) |
|-------|----------------|--|
| | | |
| | | |

34. A. Has any professional conduct or fee complaint ever been filed against you with any licensing or regulatory authority? (State licensing board; DEA; OSHA; EEOC; peer review committee; etc.)

Yes No

If "**Yes**", provide a copy of the board transcript or other documentation, including resolution and dates.

B. Have you, your legal entity, or any of your employees ever had any allegations, convictions, or related fines for Medicaid Fraud?

Yes No

B. Has any governmental agency, including a state licensing board, investigated you or taken action against either your dental and/or narcotics license, including suspension, revocation, probation, restriction, denial, or other sanction?

Yes No

If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.

C. Have you been charged with or convicted of any criminal charges (including a DUI, OWI, etc., not including minor traffic violations)?

Yes No

If "**Yes**", please provide details from investigating agency.

D. Have you ever had hospital or ambulatory surgical facility privileges involuntarily revoked, suspended or otherwise terminated? Yes

If "Yes", please provide details on additional sheet of paper.

E. Have you ever been or are you currently being treated for (if "Yes" to any, please provide a physician's statement):

- Alcoholism..... Yes No
- Drug Addiction..... Yes No
- Mental Illness..... Yes No
- Physical Impairment..... Yes No

PLEASE TELL US ABOUT YOUR PROFESSIONAL LIABILITY CLAIMS HISTORY

35. A. Has any claim or suit for alleged malpractice ever been brought against you? Yes No

If "Yes", please complete a Claim Supplement.

B. Are you currently aware of any situation that could lead to a malpractice suit against you? Yes No

If "Yes", have you reported the situation to your current insurer? Yes No

If "Yes", please complete a Claim Supplement.

PLEASE TELL US ABOUT YOUR DENTAL LABORATORY / DENTAL IMAGING SERVICES

36. Do you operate a dental laboratory? Yes No

If "Yes", do you accept referrals of patients from other dentists? Yes No

If "Yes", is there a separate business entity / corporation for this purpose? Yes No

37. Do you provide radiology services to patients of other dentists? Yes No

If "Yes", is there a separate business entity / corporation for this purpose? Yes No

PLEASE TELL US ABOUT YOUR PRACTICE

38. A. Name of your legal entity (if any): _____

Please list any associated "dba" or fictitious entity name: _____

B. Is the sole function / purpose of this entity for the practice of dentistry? Yes No

If "No", please provide details (attach a separate sheet if necessary): _____

C. If you have a legal entity, do you desire shared or separate limits of liability to apply to your legal entity?

- Shared (limits are shared with you at no cost) ***Shared limits not allowed in CT*
- Separate (entity has its own set of limits and an additional charge applies) ***Separate limits not allowed in IN*

D. Excluding yourself, name all officers or partners of your legal entity **: _____

39. If you own your own practice, please provide the number of the following who work for or with you (If none, please write "none" or "0"):

- a. Employee dentists (other than yourself and/or partners/corporate officers) ** _____
- b. Independent contractor dentists ** _____
- c. All other employees (hygienists, assistants, technicians, clerical, etc.) _____

**** NOTE:** For all employee dentists, independent contractor dentists, and/or other officers or partners of your legal entity, a separate application OR proof of current Professional Liability coverage must be attached for each.

40. Not including practice partners, employees and independent contracted dentists as indicated above, are you in a space-sharing arrangement or agreement with another Dentist, Oral Surgeon, or other Healthcare Provider? Yes No

If "Yes", please provide the following:

A. Name(s) and specialty of those with whom you are space-sharing:

| Name | Specialty |
|-------|-----------|
| _____ | _____ |
| _____ | _____ |

B. Please attach proof of current Professional Liability insurance for each individual listed in section A. above.

C. Are patient charts for all space-sharing individuals kept in or retrieved from the same area? Yes No

41. Do you now, OR have you within the past 5 years, provided professional services in a setting other than your office? (i.e., spa; residence; school; jail; prison; correctional facility; detention center; halfway house or similar type of facility for adults and/or juveniles; etc.)..... Yes No
If "Yes", provide a summary of activities and total number of hours per month: _____

42. Does your practice include mobile dentistry? Yes No
If "Yes", please answer the following questions:
A. Do you have a separate business entity / corporation set up for this purpose? Yes No
If "Yes", business entity / corporation name: _____
B. Will dentists other than yourself be providing professional services on behalf of the mobile dentistry service? Yes No
If "Yes", number of dentists: _____
C. What type of patients will you be seeing (e.g., nursing home patients, ACLF patients, school children etc.)? _____

D. If further treatment is required, is a protocol in place to instruct the patient, or Guardian thereof, to seek follow up care? Yes No
E. Please provide additional comments to help us better understand your mobile dentistry practice: _____

43. Do you practice Holistic dental services? Yes No
What percentage of your practice is Holistic? _____ If "Yes", please explain: _____

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

44. List prior insurance carrier(s) for the past three (3) years. If none, state "None."

| Name of Insurance Carrier | Effective Date | Expiration Date | Coverage Type | Limits of Liability |
|---------------------------|----------------|-----------------|---|---------------------|
| _____ | _____ | _____ | <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 | _____ |

Please explain any gaps in your insurance history: _____

45. Will you be providing dental services for which coverage is provided by another Professional Liability policy? Yes No
If "Yes", please explain: _____

46. Are you now practicing, or have you ever practiced, without Professional Liability insurance? Yes No
If "Yes", please explain: _____

47. Have you ever had any Professional Liability insurance refused, canceled, or non-renewed? Yes No
THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS
If "Yes", please explain: _____

AUTHORIZATION

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I agree that any coverage issued will be contingent upon the truth of the preceding information. I further understand that any incorrect or incomplete statement could invalidate my coverage. I hereby authorize AAIC to release the information on this application and associated underwriting information.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, KANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, PUERTO RICO, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

REMINDER TO INCLUDE:

- If no up to date website has been provided, please provide a copy of letterhead or business card (N/A if you are an Independent Contractor or Employee Dentist)
- Part time supplement – if requesting part time credit
- Employment Practices Liability Indemnity (EPLI) Supplemental Application – if requesting EPLI coverage (*Defense only coverage is automatically included at a \$25,000 sublimit*)
- Evidence of Risk Management attendance – if requesting RM credit
- “Yes” responses to certain questions require attachment of additional documents/information; is this attached?
- Copy of prior carrier declarations page (if applicable)
- Claim Supplement (if applicable)

ADDITIONAL INFORMATION MAY BE REQUESTED AND COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

Signature in full

Date

Agent’s Signature

Date

If you apply your signature to this application electronically, you hereby consent and agree that your use of a key pad, mouse or other device to affect your electronic signature constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

PRE-FILL AGENCY INFORMATION

| | | | |
|---------------------------|---|-------------------------|--|
| RETURN TO: | HEALTH AGENCIES OF THE WEST, INC. | | |
| State Administrator Name: | <u>Elizabeth Wing</u> | | |
| Address: | <u>500 N. State College Blvd., Suite 1220</u> | | |
| City: | <u>Orange</u> | State: | <u>CA</u> Zip Code: <u>92868</u> |
| Phone #: | (<u>714</u>) <u>769-3021</u> - direct line | Agent’s License Number: | <u>OG82426</u> |
| | <u>714</u> <u>769-3010</u> - fax | | <u>Elizabeth_Wing@HealthAgencies.com</u> |

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