Dental Professional Liability Insurance Application
Occurrence

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by Applicant.
3. A copy of your letterhead must be included.

I agree that any coverage issued will be contingent upon the truth of the following information:

LIMITS REQUESTD:		☐ New Policy Request Effective Date: _____/_____/_____
☐ $100,000/$300,000	☐ $2,000,000/$6,000,000	
☐ $200,000/$600,000	☐ $3,000,000/$6,000,000	☐ Renewal Rewrite of Policy Number:_____
☐ $500,000/$1,500`,000	☐ $4,000,000/$6,000,000	
☐ $1,000,000/$3,000,000	☐ $5,000,000/$6,000,000	
☐ Other: $_____/_____		Website: _____

PLEASE TELL US ABOUT YOURSELF

1. Name: (First/Middle Initial/Last/Designation) ☐ DDS ☐ DMD ☐ MD ☐ BDS

_____

2. Date of Birth: _____ Social Security Number: _____

3. A. Primary Practice Address: _____

_____

_____

County: _____ % of Time Spent at Location: _____

3. B. Secondary Practice Address: _____

_____

_____

County: _____ % of Time Spent at Location: _____

Any additional practice addresses should be listed on a separate sheet of paper. Please include the county and percentage of time spent at each location.

3. C. Mailing Address: ☐ Same as Primary Address	_____ _____ _____ County: _____

4. Telephone Number:	5. Fax Number:	6. E-Mail Address:

(_____)_____ _	(_____)_____ _	_____

7. Business structure under which you practice (Check all that apply):

A. ☐ Employee ☐ Independent Contractor ☐ Sole Proprietor ☐ Incorporated
☐ Partnership ☐ L.L.C. ☐ L.L.P. ☐ Professional Association ☐ Professional Corporation
☐ Other (describe)_____

1. Provide the name of the Legal Entity _____
2. Do you desire a shared or a separate limit of liability to apply to this entity?

☐ Shared (Limits are shared with you.) ☐ Separate (Entity has its own set of limits.)

B. Besides yourself, list the names of all dentists who are partners/corporate officers for all legal entities: (If additional space is needed, please list on a separate sheet of paper.) **(Note: All partner/corporate officers must be insured by Liberty Insurance Underwriters.)**

_____	_____	_____	_____
Name	Social Sec. #	Name	Social Sec. #
_____	_____	_____	_____
Name	Social Sec. #	Name	Social Sec. #
_____	_____	_____	_____
Name	Social Sec. #	Name	Social Sec. #

C. If you own your practice, please provide the number of the following who work for you:

	# of full-time	**# of part-time**
1. Employee dentists (other than yourself and/or partners/corporate officers)? …… (Attach separate Application or proof of Professional Liability Insurance.)	_____	_____
2. Independent Contractor dentists? …… (Attach separate Application or proof of Professional Liability Insurance.)	_____	_____
3. All other employees (i.e., hygienist, dental assistants, technicians, etc.)? ……	_____	

D. Do you work for another dentist as an independent contractor dentist? …….. Yes ☐ No ☐

If "**Yes**", please provide the name of the employer/facility: _____

E. Do you work for another dentist as an employee dentist? ……. Yes ☐ No ☐

If "**Yes**", please provide the name of the employer/facility: _____

F. Do you share dental facilities with other dentists who are not covered under this policy?…….Yes ☐ No☐

If "**Yes**", attach proof of Professional Liability Insurance for the other dentists.

8. A. Dental School Graduated: _____ Degree: _____ Year:_____

If foreign dental school graduate, are you certified by the Education Council for Dental School Graduates? …. Yes ☐ No ☐

If "**Yes**", year of certification: _____

B. Did you complete a residency? Yes ☐ No ☐ If "**Yes**", served at: _____ Month/Year: _____

C. Specialty: _____

9. Are you certified by an approved specialty board? ……. Yes ☐ No ☐

If "**Yes**", indicate "Board Certified", "Board Eligible", or Practice Limited to _____

10. Date you began practice: _____

11. What dental societies are you a member of? ….. ADA ☐ State Society ☐ Indicate State(s) _____ Other

_____

12. How many hours per week do you practice (include lab work, patient visitation and consultation)? _____
If 20 hours or less, please complete a Part-Time Supplement.

13. A. Please list the state(s) where you are currently or have previously been licensed and the corresponding license number.

State:_____ State License # _____ Current and in force?: Yes ☐ No ☐

State:_____ State License # _____ Current and in force?: Yes ☐ No ☐

State:_____ State License # _____ Current and in force?: Yes ☐ No ☐

B. DEA License # _____

14. Do you have any privileges at any hospital?? ……..Yes ☐ No ☐

If **"Yes"**, specify the name and location of hospitals and the specific procedures approved by the hospital:

_____

_____

15. Have you taken any risk management seminars in the last 3 years? ……..Yes ☐ No ☐

Date of Attendance ____/____/____ If "**Yes** ", provide evidence of attendance.

16. Indicate your Practice Specialty

☐ General Dentistry/Public Health	☐ Endodontics	☐ Oral/Maxillofacial Surgery
☐ Oral/Maxillofacial Pathology	☐ Oral/Maxillofacial Radiology	☐ Orthodontics
☐ Pediatric Dentistry	☐ Periodontics	☐ Prosthodontics
☐ Anesthesiology (Dental) – Conscious Sedation	☐ Anesthesiology (Dental) – Deep Sedation or General Anesthesia	☐ Other: _____

17. Which of the following procedures are performed by you: (Check all that apply)

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

☐ Implant Surgery ☐ Extraction of Impacted Teeth

☐ Implant Restoration ☐ Molar Endodontics on Permanent Teeth

☐ "Sargenti", paste fill or formaldehyde based endodontic techniques excluding formocresol primary tooth pulpotomies.

☐ Sleep Apnea Therapy

If "**Yes**", please indicate the following:

☐ I treat only after referral from physician. ☐ I treat without physician referral. ☐ I fabricate snore guard.

☐ Cosmetic **Dermal** Procedures (including Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.)

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

☐ Consulting Services that are provided as an extension of your primary practice (such as providing education, training, practice management consulting or expert witness testimony.)

*Is coverage desired for Consulting Services? ☐ Yes, add consulting services. (An additional charge applies.) ☐ No

☐ None of the above.

18. A. Have you ever had a change in the status of your hospital privileges? ……..Yes ☐ No ☐ N/A ☐

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

B. Has any governmental agency, including a state licensing board, ever taken action against either your dental and/or

narcotics license including suspension, revocation, probation, restriction, denial or other sanctions? …….Yes ☐ No ☐

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

C. Have you been under investigation or are you currently under investigation by any governmental agency including a state licensing board or other regulatory agency? ……..Yes ☐ No ☐

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

D. Have you been convicted of any criminal charges? ……..Yes ☐ No ☐

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

E. Have you ever been treated for alcoholism, drug addiction, mental illness or physical impairment?…….Yes ☐ No ☐

If "**Yes**", please provide a letter from the treating physician with complete details.

PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA

19. A. Is your practice limited to the use of local anesthesia, oral medication and/or nitrous oxide solely as an analgesic?….Yes ☐ No ☐

B. Are you treating patients who are under conscious sedation? ……..Yes ☐ No ☐

If **"Yes"**, please complete the Anesthesia/Sedation Supplement.

Conscious Sedation is defined as: "A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by pharmacologic or non pharmacologic methods, or a combination thereof."

C. Are you treating patients who are under general anesthesia/deep sedation? ……....Yes ☐ No ☐

If **"Yes"**, please complete the Anesthesia/Sedation Supplement.

General Anesthesia and Deep Sedation are defined as: "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."

If "**Yes**", where are the procedures performed? .....☐ In your Office ☐ In a Hospital or State Licensed Surgical Center

If "**In Your Office**", who administers the anesthesia? ☐ You ☐ Another Dentist, Anesthesiologist or CRNA

PLEASE TELL US ABOUT YOUR OFFICE PROCEDURES

20. A. Approximately how many patients do you examine or treat each working day? _____

B. Do you obtain written informed consent from your patients? Yes ☐ No ☐

C. Do you obtain a dental/medical history on all patients? ……....Yes ☐ No ☐

D. How often is this information updated? …… Every Visit ☐ Quarterly ☐ Annually ☐ Other _____

E. When do you complete your patient charts? Immediately ☐ Daily ☐ Weekly ☐ Other (explain)

_____

F. Do you record your detailed treatment plan in the patient's chart? ……....Yes ☐ No ☐

G. Do you provide a patient consultation of your treatment plan? ……....Yes ☐ No ☐

H. Is emergency equipment, including resuscitative equipment available in your office? ……....Yes ☐ No ☐

I. Is a written plan to handle emergencies available in your office, and are all employees/staff trained and familiar with it?…..... Yes ☐ No ☐

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

21. Are you now practicing, or have you ever practiced without Professional Liability Insurance?……..…...Yes ☐ No ☐

If "**Yes**", provide date and reason: _____

_____

22. Have you ever had any Professional Liability Insurance refused, cancelled or non-renewed? …Yes ☐ No ☐

If "**Yes**", provide date and reason: **(THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS)** _____

_____

23. Has any claim or suit for alleged malpractice ever been brought against you? ……...Yes ☐ No ☐

If "**Yes**", please complete Supplemental Claim Form.

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

If "**Yes**", please complete Supplemental Claim Form.

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

Insurer	**Effective Date**	**Expiration Date**	**Claims-Made or Occurrence**	**Limits of Liability**

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the Liberty Mutual Group to release the information on this Application and any associated underwriting information.

I understand that my Professional Liability Coverage will be written on an "Occurrence Form".

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

AR Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in any application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CO It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the insurance company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regards to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DC *It is a crime to provide false or misleading information to an Insurer for the purpose of defrauding the Insurer or any other person. Penalties include imprisonment and/or fine. In addition, an Insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

FL Any person who knowingly and with intent to injure, defraud, or deceive any Insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

HI For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

KY ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

LA *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 fines and confinement in prison.*

MD *Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.*

ME TN, VA and WA *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties may include imprisonment, fines or a denial of insurance benefits.*

NJ Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM 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 AND CRIMINAL PENALTIES.

NY 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.

OH 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.

OK WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any Insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

PA 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 persons to criminal and civil penalties.

IN ALL OTHER STATES:

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 fines and confinement in prison.

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

_____ _____

Signature in Full Date