

DENTAL ENTITY PROFESSIONAL LIABILITY APPLICATION

Non-Assessable Claims-Made Coverage

(Please type or print in black ink.)

APPLICANT'S INSTRUCTIONS

- A separate application must be completed for each joint venture, partnership, or corporation.
- Attach copies of all Articles of Incorporation, Partnership Agreements, etc.
- Answer all questions; if a question is not applicable, state NOT APPLICABLE.
- If space is insufficient to answer any questions fully, use Comments Section or attach separate sheet.

I. ORGANIZATION INFORMATION

1. _____

Applicant (Legal Entity Name)	Office Manager Name		

Mailing Address	City	State	Zip
()	()		
Fax No.	Phone No.	E-mail Address	Website Address

2. If the Applicant does business under any other name, please list all additional names:

3. **Desired Policy Dates**
Effective Date: _____
 Do you desire Prior Acts coverage? No Yes If yes, Retroactive Date: _____
 If Prior Acts Coverage is requested, please complete 'Section V. (Prior Acts Coverage Certification) and attach a copy of your most recent policy declarations page.

4. **Desired Limits (Each Claim/Aggregate) Choose One Option**

<input type="checkbox"/> \$1,000,000/\$1,000,000	<input type="checkbox"/> \$4,000,000/\$4,000,000
<input type="checkbox"/> \$1,000,000/\$3,000,000	<input type="checkbox"/> \$4,000,000/\$6,000,000
<input type="checkbox"/> \$2,000,000/\$2,000,000	<input type="checkbox"/> \$5,000,000/\$5,000,000
<input type="checkbox"/> \$2,000,000/\$4,000,000	<input type="checkbox"/> \$5,000,000/\$7,000,000
<input type="checkbox"/> \$3,000,000/\$3,000,000	<input type="checkbox"/> \$6,000,000/\$6,000,000
<input type="checkbox"/> \$3,000,000/\$5,000,000	<input type="checkbox"/> \$6,000,000/\$8,000,000

5. Will the Applicant be covered by any additional professional liability insurance policy with any other insurance company?
 No Yes – Please explain and provide evidence of such coverage:

I. ORGANIZATION INFORMATION

6. Please list all office locations (if additional space is needed, attach a separate sheet of paper).

Location #1:

Street Address	(number, suite, etc.)	City	State	Zip
	()		()	
County	Telephone Number	Federal Tax ID Number	Fax Number	

I. ORGANIZATION INFORMATION (continued)

Location #2:

Street Address (number, suite, etc.) City State Zip
County Telephone Number Federal Tax ID Number Fax Number

Location #3:

Street Address (number, suite, etc.) City State Zip
County Telephone Number Federal Tax ID Number Fax Number

- 7. Type of Organization (select the one most appropriate):
8. Type of Legal Entity (select the one most appropriate):
9. If the Applicant owns a subsidiary(ies), disclose that subsidiary here and indicate its type of Organization and services provided:

II. GENERAL INFORMATION

Please fully explain any "Yes" answer in Comments Section (last page) or attach separate sheet.

- 1. Does the Applicant's collection agency have authority to file a collection suit at its discretion without prior approval of the Applicant?
2. Has the Applicant or any of its employees:
3. Does the Applicant maintain current Certificates of Insurance on file for all dentists employed or contracted to work at its facility(ies)?
4. Does the Applicant provide any level of conscious sedation by intravenous or oral route?
5. Please include annual numbers for:
6. Does the Applicant comply with OSHA and ADA guidelines for infection control?
7. Does the Applicant have designated personnel responsible for carrying out the following:

II. GENERAL INFORMATION, continued

8. Provide the number of employed and contracted non-dentist personnel.

Dental Hygienists		Dental Assistants		Laboratory Technicians	
Sterilization Technicians		Radiology Technicians			
Other, please describe					

9. List all of Applicant's employed and contracted dentists, and provide the requested information for each listed individual.

Last name first, then first and middle initials (e.g. Smith, J. G.)	Degree	(S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	Professional Liability Carrier (If not Medical Security, attach a Certificate of Insurance)	Specialty

III. APPLICANT'S INSURANCE COVERAGE INFORMATION

1. Please list insurance information for the past ten (10) years or to requested retroactive date, whichever is greater.

	Current Carrier	First Prior Carrier	Second Prior Carrier	Third Prior Carrier	Fourth Prior Carrier
Insurance Company					
Policy Number					
Coverage form	<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	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Dates of Coverage					
Limit of Liability Per claim/aggregate					
Deductible and amount (If applicable)	<input type="checkbox"/> Deductible \$	<input type="checkbox"/> Deductible \$	<input type="checkbox"/> Deductible \$	<input type="checkbox"/> Deductible \$	<input type="checkbox"/> Deductible \$
Retroactive Date					

2. Have you ever had any professional liability insurance refused, cancelled, or non-renewed? No Yes
 If yes, please explain _____

IV. CLAIMS HISTORY

ATTACH CURRENT "LOSS RUN" (No more than 90 days old) FOR PREVIOUS 10 YEARS OF PRACTICE. (A loss run is a document from your previous professional liability carrier(s) verifying claims, suits or reported incidents.) YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

1. Have any claims or suits been brought against you, or have you reported any incidents to your current carrier concerning your professional services? No Yes

2. Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against you? No Yes

IF "YES" TO 1 OR 2 ABOVE, PLEASE COMPLETE THE FOLLOWING FOR EACH SUCH CIRCUMSTANCE. IF YOU NEED MORE SPACE, USE COMMENTS SECTION (LAST PAGE) OR ATTACH ADDITIONAL SHEET. FOR PAID CLAIMS, PLEASE ATTACH A COPY OF THE NATIONAL PRACTITIONER DATA BANK SUBMISSION.

CLAIM, SUIT OR INCIDENT #1

Patient's Name	Date of Occurrence
Insurance Carrier	Location of Occurrence
Date Claim reported: <input type="checkbox"/> N/A	Amount reserved on your behalf \$
Date Claim closed: <input type="checkbox"/> N/A	Amount paid on your behalf \$

Allegation(s):

CLAIM, SUIT OR INCIDENT #2

Patient's Name	Date of Occurrence
Insurance Carrier	Location of Occurrence
Date Claim reported: <input type="checkbox"/> N/A	Amount reserved on your behalf \$
Date Claim closed: <input type="checkbox"/> N/A	Amount paid on your behalf \$

Allegation(s):

V. PRIOR ACTS COVERAGE CERTIFICATION

(Complete if Prior Acts Coverage is requested in Section I. Organization Information)

I request Prior Acts Coverage retroactive to: _____(date), which is consistent with the attached Declarations page from my current carrier.

I certify that I have no knowledge of any professional liability claims which have been asserted against this applicant, or any related professional corporation or professional association for which I am seeking coverage, which have not been reported to my prior or applicable carrier.

I furthermore certify I have no knowledge of any occurrence, incident or circumstance likely to result in such a claim as of this date, other than those reported on this application.

Notice of any such claim, occurrence, incident or circumstance should be given to your current carrier if such notice has not already been provided. This policy will not provide coverage for any such claim, occurrence, incident or circumstance.

I certify that the above is true, complete and correct to the best of my knowledge, information and belief. I understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

Authorized Representative of Applicant Title Date

VI. AUTHORIZATION AND RELEASE

(This authorization and release must be signed by an authorized representative of the Applicant.)

I, the undersigned authorized representative of the Applicant, understand that this is an application for insurance and is not an insurance binder and acknowledge that the foregoing statements and answers are complete and correct to the best of my knowledge and belief. I further understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of the Applicant's protection if coverage is written as a result of this application.

I, the undersigned authorized representative of the Applicant, authorize the release and exchange of information involving either underwriting or claim matters between the Applicant's present or prior insurance carrier, any hospital and other dentists and Medical Security Insurance Company. I, on behalf of the Applicant, hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and Medical Security Insurance Company, its directors, officers, employees, or agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization.

Authorized Representative of Applicant Title Date

Name and Address of Agent:

Signature of Agent Date

Please return completed application to
Medical Security Insurance Company
Attention: Underwriting Department
PO Box 98028
Raleigh, NC 27624-8028

VII. COMMENTS SECTION

QUESTION #	COMMENTS