

DENTAL PRACTITIONERS PROFESSIONAL LIABILITY APPLICATION
Non-Assessable Claims-Made Coverage

Please answer all questions completely and as they relate to the coverage being applied for. If a question does not apply to you, write "N/A". Do not leave any question unanswered. If space is inadequate, use Comments Section (last page) or attach separate sheet.

I. PERSONAL/PROFESSIONAL DATA

Applicant Name (last, first, middle, designation)			Date of Birth (mm/dd/yy)		
Practice Name					
Primary Practice Address	City	State	Zip Code	County	
Residence Address	City	State	Zip Code	County	
Telephone - Office ()	Fax - Office ()		Telephone - Residence ()		
Social Security Number	E-mail Address		Mobile Telephone Number		
Additional Practice Locations					
	Practice Name	Street Address	City	State	Zip Code
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

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 the Section V. Prior Acts Coverage Certification on page 5 of this application and attach a copy of your most recent policy declarations page.

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 |

II. DENTAL TRAINING AND HISTORY

1. Dental Education

A. Dental School: Institution	State	From	To	Completed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
B. Residency: Institution	Specialty	State	From	To	Completed? <input type="checkbox"/> No <input type="checkbox"/> Yes
C. Fellowship: Institution	Specialty	State	From	To	Completed? <input type="checkbox"/> No <input type="checkbox"/> Yes

III. INSURANCE HISTORY

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

1. Carrier Information:

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

2. Has your liability insurance ever been surcharged, written with a deductible or written in a non-standard market?

- No Yes - If Yes, Explain: _____

3. Has your professional liability insurance ever been canceled, suspended, non-renewed or declined; or have you ever voluntarily withdrawn your application for professional liability coverage?

- No Yes – If yes, Explain: _____

4. Have you previously had professional liability insurance provided by Medical Security? No Yes

5. If your current professional liability insurance is a claims-made policy and you are not requesting prior acts coverage, are you obtaining Extended Reporting (“tail”) coverage from your current insurance company?

- Yes No If No, please explain _____

IV. CURRENT DENTAL PRACTICE

1. Do you practice General Dentistry? NO YES

A. If not practicing General Dentistry, please indicate practice specialty:

- | | | |
|------------------------------------------------|-------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Oral Pathology | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Endodontics |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Periodontics |
| <input type="checkbox"/> Prosthodontics | <input type="checkbox"/> Oral & Maxillofacial Surgery | <input type="checkbox"/> Oral Facial Pain |
| <input type="checkbox"/> Dental Anesthesiology | <input type="checkbox"/> Dental Radiology | <input type="checkbox"/> Other _____ |

B. Are you Board Certified? NO YES

Board Certified by: _____ Certification exp. date: _____

C. Do you limit your practice to any particular procedure(s)? NO YES

If yes, identify the procedure(s): _____

2. Do you administer any of the following types of sedation? Please check only those procedures that you perform in your practice or hospital setting. Include a copy of your Application for your Permit and your issued State Board Permit and any other related documentation of additional training obtained.

INHALATION ANALGESIA: Nitrous Oxide Inhalation

ANXIOLYSIS: *No Permit Required

Pharmacological reduction of anxiety through the administration of a **single dose of a minor psychosedative, possibly in combination with nitrous oxide, to children or adults prior to commencement of treatment on the day of the appointment** which allows for uninterrupted interactive ability in a totally awake patient with no compromise in the ability to maintain a patent airway continuously and without assistance. Nitrous Oxide administered in addition to the minor psychosedative does not constitute multiple dosing.

IV. CURRENT DENTAL PRACTICE, continued

MINIMAL CONSCIOUS SEDATION: *Requires Permit

Conscious sedation characterized by a minimally depressed level of consciousness, in which patient retains the ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command, provided to patients 13 years or older, by oral or rectal routes of **administration of a single pharmacological agent, in one or more doses**, not to exceed the manufacturer's maximum recommended dose, at the time of treatment, possibly in combination with nitrous oxide. Minimal conscious sedation is provided for behavioral management.

MODERATE CONSCIOUS SEDATION *Requires Permit

Conscious sedation characterized by a drug induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to patients 13 years of older, by oral, nasal, rectal or parenteral routes (IV/IM) of administration of multiple pharmacological agents, in multiple doses, within a 24 hour period, including the time of treatment, possibly in combination with nitrous oxide. Moderate conscious sedation is provided for behavioral control.

MODERATE CONSCIOUS SEDATION LIMITED TO ORAL ROUTES AND NITROUS OXIDE INHALATION *Requires Permit

Conscious sedation characterized by a drug induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to patients 13 years of older, by oral routes of administration and nitrous oxide inhalation, of **single or multiple pharmacological agents, in single or multiple doses**, within a 24 hour period. Moderate conscious sedation limited to oral routes and nitrous oxide inhalation is provided for behavioral control.

MODERATE PEDIATRIC CONSCIOUS SEDATION *Requires Permit

Conscious sedation characterized by a drug induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to **patients under 13 years of age, by oral, nasal, rectal or parenteral routes** of administration of **single or multiple pharmacological agents, in single or multiple doses**, within a 24 hour period, including the time of treatment, possibly in combination with nitrous oxide. Moderate pediatric conscious sedation is provided for behavior control.

3. **Please check the appropriate boxes relating to the location (s) you administer conscious sedation or general anesthesia.**

- office only hospital only both not applicable

4. **Part-Time Practice: Do You Practice Dentistry On A Part-Time Basis (less than 20 hours per week)?** No Yes If Yes, answer the following questions:

A. Which of the following describes your present part-time situation (check the appropriate category)?

- Semi-retired due to age. Date of retirement: _____
- Semi-retired due to health. Please provide date of partial disability, health condition that caused you to reduce your practice, and name of treating physician: _____
- Practice full-time, but am applying for coverage for only a portion of my professional dental activities. Please explain and provide evidence of coverage for those activities not intended to be covered by the Company. Identify which applies:

Residency or Fellowship program _____
Military service or Federal Government agency _____
Other part-time situation not described above. Please explain, including name of employer and location.

B. Indicate the average number of hours per week of your part-time practice devoted to each of the following for which the Company is to provide coverage.

- a. Office Practice = _____ hours/week
- b. Hospital Practice = _____ hours/week
- c. Other--please explain: = _____ hours/week

C. What are your arrangements for emergency coverage when you are not available?

Part-time discounts are not available to oral surgery specialties.

IV. CURRENT DENTAL PRACTICE, continued

5. Are you a (an)

<input type="checkbox"/> Employee of a partnership/corporation	<input type="checkbox"/> Independent Contractor
<input type="checkbox"/> Employee of a hospital or clinic	<input type="checkbox"/> Partner in a partnership or shareholder in a professional corporation or association
<input type="checkbox"/> Employee of a government agency	<input type="checkbox"/> Solo unincorporated

6. Are you employed by or contracted with any dental placement agencies to provide dental services? Yes No If yes, please explain including the name(s) of the agencies and whether Medical Security is to be your insurer for such services. If coverage is to be provided by the agency, please attach a Certificate of Insurance.

7. Do you share or lease office space? No Yes – Explain:_____

8. Do you have a Solo Professional Limited Liability Corporation (PLLC) or Solo Professional Association (PA)? (Solo PC or Solo PA will share in the dentist's individual limit at no additional charge)

No Yes – If "Yes", please answer the following:

A. Name of legal entity:_____

B. Date PLLC or PA was formed:_____

C. Have there been any settlements/judgments made on behalf of your PC or PLLC, or any claims pending?
 No Yes If "Yes", complete *Section VI. Claims History*

D. If you are the employing dentist, please indicate the number of the following support staff you employ:
 _____Dental Hygienists _____Dental Assistants _____Other dental care providers –please specify titles(s)_____

***** If two or more dentists are practicing under your corporation and you wish to request separate coverage for that Corporation, an entity application must be completed.**

9. Do you have any dentistry related duties that are insured by another company or for which you do not desire Medical Security Insurance Company coverage? No Yes If yes, please explain:_____

10. a. What is the average number of patients treated by your total practice per day? _____
 b. What is the average number of patients you treat per day? _____

11. Do you treat TMD (temporomandibular disorder)? No Yes

If yes, please check the one that describes your practice:

Conservative -- Splints, Occlusal Adjustment, Medication
 or

Semi-invasive -- TENS, Biofeedback, Injection, Surgery

Do you receive referrals for TMD treatment? No Yes

V. PRIOR ACTS COVERAGE CERTIFICATION

(From page 1, complete if Prior Acts Coverage is requested. You may skip this Certification if prior acts are not requested.)

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 me, or any related professional corporation or professional association for which I am seeking coverage, which have not been reported to my prior 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.

V. PRIOR ACTS COVERAGE CERTIFICATION, continued

Notice of any such claim(s), occurrence(s), incident(s) or circumstance(s) 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.

Signature of Applicant **Date**

VI. CLAIMS HISTORY

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

1. Have any claims or suits been brought against you, or have you reported any incidents 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 EITHER QUESTION ABOVE, PLEASE COMPLETE THE FOLLOWING FOR EACH SUCH CIRCUMSTANCE. IF YOU NEED MORE SPACE, USE "COMMENTS SECTION" 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 \$

VI. CLAIMS HISTORY, continued

Allegation(s):

VII. AUTHORIZATION AND RELEASE

(This authorization and release must be signed by the Applicant.)

I, the undersigned Applicant, understand that this is an application 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 my protection if coverage is written as a result of this application.

I, the undersigned Applicant, authorize the release and exchange of information involving either underwriting or claim matters between my present or prior insurance carrier, any hospital and other physicians and Medical Security Insurance Company. I 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.

Signature of Applicant

Date

Name and Address of Agent:

Signature of Agent

Date

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

COMMENTS SECTION, use additional sheet if necessary

QUESTION #

COMMENTS

QUESTION #	COMMENTS