

**RETIRED VOLUNTEER HEALTHCARE PROFESSIONAL APPLICATION**

Answer all questions which apply to your practice. Coverage will not be considered until this application is fully completed and all necessary documents have been received.

*(Please TYPE or PRINT in black ink.)*

**I. GENERAL INFORMATION**

Applicant Name (last, first, middle, designation)			Date of Birth (mm/dd/yy)	
Mailing Address	City	State	Zip Code	County
NC Dental License Number	State	Expiration Date	Status	
Dental Specialty	Sub-specialty			

- Desired Policy Effective Date: \_\_\_\_\_  
*Note: The only limits of liability available under the Retired Volunteer Healthcare Professional Program are \$1,000,000 each incident/\$3,000,000 annual aggregate.*
- Total number of hours spent each month in a professional capacity as a healthcare professional volunteer: \_\_\_\_\_ hours
- Name and address of volunteer location \_\_\_\_\_  
\_\_\_\_\_
- Duties at the volunteer location \_\_\_\_\_
- Date officially retired from the practice of dentistry: \_\_\_\_\_
- Number of hours of continuing education completed within the past two years: \_\_\_\_\_ hours
- Is all the work you provide in a professional capacity as a healthcare professional done without remuneration?  Yes  No
- Are you performing any type of invasive or surgical procedures?  Yes  No

Please be advised that this policy will not cover any type of invasive or surgical procedures or any type of services provided for remuneration.

**II. PERSONAL AND INSURANCE HISTORY**

- Has your dental or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked or restricted in any location?  
 No  Yes - Explain: \_\_\_\_\_

**II. PERSONAL AND INSURANCE HISTORY (continued)**

2. Have you ever been or are you currently under a “consent order”?  No  Yes - Attach copy
3. Have you ever been diagnosed with, or treated for, alcoholism, drug addiction, or mental or physical impairment?  No  Yes – Explain and provide dates and locations of all treatment or evaluations as well as names of your supervising and/or monitoring physicians.

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4. Have you ever been questioned, investigated, or requested to appear before any of the following:
- A. A state licensing board or equivalent?  Yes  No
- B. A specialty or dental association?  Yes  No
- C. A Medicare/Medicaid agency?  Yes  No
- D. Other?  Yes  No

If “Yes”- Explain: \_\_\_\_\_

5. Have you ever been charged with any criminal activity?

No  Yes - Explain: \_\_\_\_\_

6. Has any claim or suit for alleged sexual misconduct ever been brought against you?

No  Yes - Explain: \_\_\_\_\_

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

No  Yes - Explain: \_\_\_\_\_

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8. Provide the following information regarding your professional liability insurance for the most recent five (5) years. Use additional sheet if necessary:

	First Prior Carrier	Second Prior Carrier	Third Prior Carrier	Fourth Prior Carrier	Fifth Prior Carrier
<b>Insurance Company</b>					
<b>Policy Number</b>					
<b>Policy Period</b>					

**III. CLAIMS HISTORY**

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 1 or 2 above, please complete the following for each such circumstance. If you need more space, attach additional sheet.*

**CLAIM, SUIT OR INCIDENT**

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

**Allegation(s):**

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**IV. AUTHORIZATION AND RELEASE**

I 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 void 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 dentists and the Company. I hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and the 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.

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Signature of Retired Volunteer Healthcare Professional Applicant

Date