

ProAssurance Indemnity Company, Inc. • PO Box 590009 • Birmingham, AL 35259-0009 • 800.625.7814 • Fax 205.868.4040

With your fully completed, signed and dated application, you must submit the following information:

1. Current insurance policy declarations page.
2. Copy of extended reporting endorsement (tail) from your current carrier if your current coverage is claims-made and you are *not* applying for Prior Acts Coverage.
3. Loss runs from all prior insurance companies or explanation as to why they are not available.
4. Current business letterhead.

**1. Personal Information**

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Gender: Male  Female

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Dental License Number(s):	State	License Number	Expiration Date	% of Practice
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Professional Membership(s):  ADA (membership level): \_\_\_\_\_

AGD (membership level): \_\_\_\_\_

Other: \_\_\_\_\_ Membership #: \_\_\_\_\_

**2. Practice Location**

Practice Name: \_\_\_\_\_

Practice Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Website: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Email Address: \_\_\_\_\_

**Please list other practice locations:**

Practice Name: \_\_\_\_\_

Practice Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Dates: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Percent of Practice: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Dates: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Percent of Practice: \_\_\_\_\_

### 3. Coverage Requested

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- A. Requested effective date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR
- B. Please indicate your desired level of coverage.  
Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): \_\_\_\_\_ / \_\_\_\_\_  
Excess Coverage Limits (where available): \_\_\_\_\_
- C. Do you desire coverage for a practice entity? Yes  No   
If yes, we require a corporate application to be completed.

### 4. Prior Acts Coverage

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(Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.)

- A. Are you requesting Prior Acts Coverage? If no, please skip to Section 5. Yes  No   
Retroactive Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR
- B. During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g., different states, procedures, coverages, etc.). Yes  No   
If yes, please describe the changes in your practice, including all applicable dates in the space at the end of the application.

### 5. Education and Training

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- A. Please list the name and location of all dental schools attended:
- | Institution and Location | Dates Attended | Degree Obtained |
|--------------------------|----------------|-----------------|
| _____                    | _____          | _____           |
| _____                    | _____          | _____           |
- B. Please list any post-graduate training:
- | Institution and Location | Dates Attended | Degree Obtained |
|--------------------------|----------------|-----------------|
| _____                    | _____          | _____           |
| _____                    | _____          | _____           |
- C. Are you board certified in any specialty or have you completed a General Practice Residency?  Yes  No  
If yes, please list board certified specialty GPR: \_\_\_\_\_

### 6. Practice Information

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- A. Do you practice as (check one):
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Solo Unincorporated | <input type="checkbox"/> Partner in a Partnership                  | <input type="checkbox"/> Employee               |
| <input type="checkbox"/> Solo Corporation    | <input type="checkbox"/> Shareholder in a Professional Corporation | <input type="checkbox"/> Independent Contractor |
- B. Please check and indicate percentage of time you practice in each. Total must equal 100%:
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> General Dentistry _____% | <input type="checkbox"/> Pediatric Dentistry _____%           | <input type="checkbox"/> Endodontics _____%    |
| <input type="checkbox"/> Periodontics _____%      | <input type="checkbox"/> Oral or Maxillofacial Surgery _____% | <input type="checkbox"/> Prosthodontics _____% |
| <input type="checkbox"/> Orthodontics _____%      | <input type="checkbox"/> Oral Radiology _____%                | <input type="checkbox"/> Oral Pathology _____% |
| Other _____%                                      |   |  |

C. Please check and indicate procedures you perform and percent of your practice (total must equal 100%):

- Cosmetic:**  Intra-oral \_\_\_\_\_%  Extra-oral (Botox/dermal fillers and similar procedures) \_\_\_\_\_%
- Oral Surgery:**  Minor (Alveolar) \_\_\_\_\_%  Major (other procedures) \_\_\_\_\_%
- Extractions:**  Simple \_\_\_\_\_%  Full Impacted \_\_\_\_\_%  Partial Bony Impacted \_\_\_\_\_%
- Do you do third molar extractions?  Yes  No
- Implants:**  Initial Surgical \_\_\_\_\_%  Restorations \_\_\_\_\_%
- Endodontics:**  Single-rooted endodontics \_\_\_\_\_%  Multi-rooted endodontics \_\_\_\_\_%
- Prosthodontics:**  Single unit bridge/crown \_\_\_\_\_%  Multi-unit bridge/crown \_\_\_\_\_%
- Full mouth dentures \_\_\_\_\_%  Denture adjustment and repair \_\_\_\_\_%
- Periodontics:**  Scaling/root planing \_\_\_\_\_%  Soft tissue surgery \_\_\_\_\_%
- Soft tissue grafts \_\_\_\_\_%  Bone grafts \_\_\_\_\_%
- Orthodontics:**  Comprehensive orthodontics \_\_\_\_\_%  Minor tooth guidance \_\_\_\_\_%
- Pain Management:**  Treatment of TMD \_\_\_\_\_%  Other (describe) \_\_\_\_\_%
- Other:**  Surgical procedures \_\_\_\_\_%
- Non-surgical procedures \_\_\_\_\_% Describe: \_\_\_\_\_

If none of the above procedures apply to your practice, please initial here: \_\_\_\_\_

D. Anesthesia/Sedation

1. Check the type of anesthesia and/or sedation used in your practice and number of procedures done per year in an office or hospital practice, and who administers the anesthesia/sedation.

- |   |   |
|---|---|
| <input type="checkbox"/> Local and/or Nitrous Oxide Only<br>In Office _____ In Hospital _____<br>Who Administers: _____             | <input type="checkbox"/> IV/IM Moderate Sedation<br>In Office _____ In Hospital _____<br>Who Administers: _____ |
| <input type="checkbox"/> Oral Moderate Sedation (sedation dentistry)<br>In Office _____ In Hospital _____<br>Who Administers: _____ | <input type="checkbox"/> General Anesthesia<br>In Office _____ In Hospital _____<br>Who Administers: _____      |

\*Please note: If you checked IV/IM sedation, oral moderate sedation, or general anesthesia, we may require a supplemental application to be completed.

2. Please indicate your certification information:

- ACLS  BCLS  PALS

3. Do you require that your staff be certified (ACLS, BCLS, or PALS)?

Yes  No

E. How many hours a week do you practice? \_\_\_\_\_ Date you established this schedule: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

F. Do you teach in a dental school?

Yes  No

If yes, indicate how many hours per week and if coverage is provided through the dental school in the space provided at the end of the application.

G. Do you treat or review treatment of inmates in a correctional institution?

Yes  No

If yes, list the correctional institution, percent of your total practice time, and if coverage is provided through the facility in the space provided at the end of the application.

H. Do you treat patients via a mobile dental unit?

Yes  No

If yes, please list percent of your total practice time: \_\_\_\_\_%

I. Do you treat or review treatment of patients in a nursing home facility?

Yes  No

If yes, please list percent of your total practice time: \_\_\_\_\_%

J. Do you treat sleep apnea patients?

Yes  No

If yes, do you ever treat without a physician referral?

Yes  No

K. Do you perform any procedures that are clinical trials, experimental, not usual or customary to the specialty or that are not approved by the ADA or the FDA?

Yes  No

If yes, describe in the space provided at the end of the application.

L. Do you provide elective facial cosmetic procedures, Botox, collagen injections, or other dermal fillers for cosmetic purposes in your practice?

Yes  No

M. Do you perform procedures outside the oral and maxillofacial region?

Yes  No

If yes, describe procedures and number provided per year in the space provided at the end of the application.

N. Do you provide forensics or expert witness testimony?

Yes  No

**7. Insurance History and Claim Information**

A. Current Insurance Information:

- i. Name of Insurer: \_\_\_\_\_
- ii. State Where Practiced: \_\_\_\_\_
- iii. Policy Limits: \_\_\_\_\_
- iv. Dates Covered, From: \_\_\_\_\_ To: \_\_\_\_\_
- v. Policy Type: Claims-Made  Occurrence
- vi. If Claims-Made, Retro Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR
- vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes  No

B. Previous Insurance Information:

- i. Name of Insurer: \_\_\_\_\_
- ii. State Where Practiced: \_\_\_\_\_
- iii. Policy Limits: \_\_\_\_\_
- iv. Dates Covered, From: \_\_\_\_\_ To: \_\_\_\_\_
- v. Policy Type: Claims-Made  Occurrence
- vi. If Claims-Made, Retro Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR
- vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes  No

C. Previous Insurance Information:

- i. Name of Insurer: \_\_\_\_\_
- ii. State Where Practiced: \_\_\_\_\_
- iii. Policy Limits: \_\_\_\_\_
- iv. Dates Covered, From: \_\_\_\_\_ To: \_\_\_\_\_
- v. Policy Type: Claims-Made  Occurrence
- vi. If Claims-Made, Retro Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR
- vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes  No

D. Will you be carrying additional liability insurance with another company? Yes  No

If yes, provide name of company, limits, expiration date, and services covered in the space provided at the end of the application.

If you answer yes to questions E, F, or G, including any sub-questions, please complete the attached Supplementary Claims Information Form.

E. Have you *ever* been involved in a dental professional liability claim or suit? The word “claim” as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership. Yes  No

F. Other than the situations indicated in 7.E. above, are you aware of any of the following circumstances:

- i. A request for records from a patient, family member, attorney, or patient representative related to an adverse outcome or treatment of a patient? Yes  No
- ii. A letter from an attorney regarding your treatment of a patient? Yes  No
- iii. A patient, family member, or patient representative’s dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes  No
- iv. Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes  No

G. Have all circumstances in question 7.F. above been reported to your current or prior professional liability carrier? Yes  No  N/A\*

If yes, how many? \_\_\_\_\_ Please attach documentation of all such reports.

If no, please explain in space provided at the end of the application.

\*For purposes of this question, N/A means that you answered “No” to each subpart of question 7.F.

H. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? *This question is not applicable in Missouri.* Yes  No

## 8. Personal History

(If you answer yes to any of the following questions, provide complete details in the space provided at the end of the application or on a separate sheet.)

- A. Have you ever been treated for alcoholism, drug addiction, sexual addiction, or mental illness? Yes  No
- B. Are you aware of, or in a treatment program for, any health impairment or disability that may affect your ability to perform professionally? Yes  No
- C. Have you ever been convicted of, pled guilty to, or pled no contest to a felony? Yes  No
- D. Have you ever been convicted of, pled guilty to, or pled no contest to a violation of any law or ordinance (other than minor traffic offenses), including driving while under the influence of alcohol or any other substance? Yes  No
- E. Have you ever failed any licensing or Board Certification examinations? Yes  No
- F. Has your license to practice dentistry or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? Yes  No
- G. Have you ever appeared before, been investigated by, or entered into any consent agreement with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes  No
- H. Have you ever had a patient or patient representative complain to or file a grievance of any type with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes  No
- I. Have you ever voluntarily surrendered your hospital privileges, narcotics or professional license to avoid suspension, restriction, probation, or revocation? Yes  No
- J. Has any hospital ever restricted, suspended, revoked, or refused your privileges or has probation ever been invoked? Yes  No
- K. Have you ever been accused of sexual misconduct or inappropriate physical contact? Yes  No

**Fraud Warning** – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

### Texas Purchasing Group Intent to Join

The undersigned insured hereby consents to join the American Dental Professional Liability Purchasing Group, a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

### Virginia Purchasing Group Intent to Join

The undersigned insured hereby consents to join the ProAssurance Healthcare Providers Purchasing Group, a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

### Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information section which requires your signature. Please read it carefully.



**Dentist's Supplementary Claims Information Form**

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

- 1. Patient's Name: \_\_\_\_\_
- 2. Date Reported to Insurance Company: \_\_\_\_\_
- 3. Name of Insurance Company: \_\_\_\_\_
- 4. Name and Address of the Attorney Assigned to Your Case: \_\_\_\_\_
- 5. Date of Incident and Your Treatment: \_\_\_\_\_
- 6. Allegations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. What is the present condition of the patient? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes  No

9. Status of claim (check applicable answer):

- Suit threatened, no action taken
- Suit filed, but dropped by claimant
- Summary Judgment in your favor
- Suit settled Out-of-Court  
Date claim paid: \_\_\_\_\_  
Amount paid: \_\_\_\_\_

- Court outcome in your favor
  - Jury verdict
  - Directed verdict
- Court outcome in favor of plaintiff
  - Jury verdict
  - Directed verdict
- Amount of Loss: \_\_\_\_\_

- Awaiting mediation
- Awaiting court action
- Reserve Amount: \_\_\_\_\_

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes  No   
If yes, amount was: \$ \_\_\_\_\_

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_