Dentist's Advantage
PROFESSIONAL LIABILITY & PRACTICE PROTECTION

Return completed application to:
Dentist's Advantage
159 East County Line Road
Hatboro, PA 19040
Or fax it to 877-250-1527 Questions? Call 866-219-6533
Or visit our website at www.dentists-advantage.com

Dentists Professional Liability Application

National Union Fire Insurance Company of Pittsburgh, Pa.
2704 Commerce Drive, Suite B, Harrisburg, PA 17110
Administrative Offices: 175 Water Street, New York, NY 10038
(A Capital Stock Insurance Company)

NOTICE: THERE MAY BE BOTH OCCURRENCE COVERAGES AND CLAIMS MADE COVERAGES IN THIS POLICY. CLAIMS MADE COVERAGE IS LIMITED TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED AND REPORTED IN WRITING TO US DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

A. GENERAL INFORMATION

Please type or print. EVERY ITEM MUST BE COMPLETED. If not applicable, write N/A. If additional space is required, please provide your answers on a copy of your practice letterhead.

MEMBER # _____

1. _____ DDS _____
FIRST NAME MIDDLE INITIAL LAST NAME

DMD _____

2. _____
NATIONAL PROVIDER ID #

3. _____ **4.** _____
NAME OF PRACTICE NAME OF PRIMARY CONTACT /FIRST & LAST

5. Primary Mailing Address:

_____
STREET CITY COUNTY STATE ZIP

6. Primary Office Location/Address:

_____
STREET CITY COUNTY STATE ZIP

7. Additional Practice Location:

_____
STREET CITY COUNTY STATE ZIP

8. Contact Information:

a. (_____)_____ **b.** (_____)_____ **c.** _____
BUSINESS PHONE NUMBER RESIDENCE PHONE NUMBER E-MAIL ADDRESS

d. (_____)_____ **e.** (_____)_____ **f.** _____
FAX NUMBER CELL PHONE NUMBER WEB PAGE URL

B. COVERAGE INFORMATION

1. When did you start private practice? _____/_____/_____ (M D Y)

2. Requested Policy Effective Date: _____/_____/_____ (M D Y)

3. ☐ **Claims Made** Coverage OR ☐ **Occurrence** Coverage

3a. If Claims Made coverage: Please include a copy of your current Declarations Page AND provide retroactive date: _____/_____/_____ (M D Y)

4. Coverage Options: Please check the coverage Options and Limits you desire:

☐ **Option 1 Dental Professional Liability Only**

☐ **Option 2 Dental Professional Liability and Business Liability Coverages** including General Liability, Employee Benefits Liability, Employment Practices Liability*, Hired/Non-Owned Automobile Liability and Medical Waste Legal Expense Reimbursement (*Employment Practices Liability: $5,000 limit may be increased.) Please check with your agent for a quote.

☐ **Business Owners and Workers' Compensation coverage can also be purchased. Please send me information.**

DENTAL PROFESSIONAL LIABILITY LIMITS

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

☐ $1,300,000/$3,900,000 (NY Only) ☐ $2,000,000/$6,000,000 ☐ $3,000,000/$6,000,000

☐ $4,000,000/$6,000,000 ☐ $5,000,000/$6,000,000

Please check desired limit option above. NOTE: All limit options may not be available in all states.

5. Current Insurer: _____ **a.** $_____ **b.** $_____
NAME OF INSURANCE COMPANY | LIMITS OF LIABILITY | ANNUAL PREMIUM

6. Please list all states that you practice in, your license number for each state and what percentage of time you practice there:

a. _____ **b.** _____ **c.** _____ **d.** _____ **e.** _____ **f.** _____
STATE | LICENSE # | % OF PRACTICE | STATE | LICENSE # | % OF PRACTICE

7. Consent Waiver **(May not be available in all states)**: Do you wish to waive the provision in the policy requiring us to obtain your consent in order to settle a claim against you? (Note: A premium credit may apply. Not available in all states.) ..... ☐ Yes ☐ No

C. EDUCATION

1. Are you a General Dentist? ..... ☐ Yes ☐ No

2. If limiting your practice to a specialty, are you licensed in that specialty? ..... ☐ Yes ☐ No

3. What is your specialty?

☐ Periodontist ☐ Prosthodontist ☐ Endodontist
☐ Pediatric Dentist ☐ Orthodontist ☐ Oral Pathologist
☐ Oral Surgeon ☐ Public Health Dentist ☐ Oral Radiologist

4. Are you a current member of the AGD? ..... ☐ Yes ☐ No

a. If Yes, AGD Membership Number _____

b. AGD Fellowship? ..... ☐ Yes ☐ No

c. AGD Mastership? ..... ☐ Yes ☐ No

5. Are you a current member of the NDA? ..... ☐ Yes ☐ No

6. Are you a member of any dental organization(s)? ..... ☐ Yes ☐ No

If "Yes" please provide the name(s) of the organization(s):_____

_____

_____

7. List your training and education.
(If more space is required, use a sheet of practice letterhead).

a. _____ _____
U.S. DENTAL SCHOOL/DEGREE | DATE COMPLETED

_____ _____ _____
CITY | STATE | COUNTRY

b. _____
PROGRAM

c. Are you a Foreign Dental School Graduate? ..... ☐ Yes ☐ No

_____
NAME OF FOREIGN DENTAL SCHOOL | DATE COMPLETED

_____
COUNTRY | PROFESSIONAL DEGREE

d. _____
RESIDENCY LOCATION | DATE COMPLETED

e. _____
POST GRADUATE CERTIFICATION – CV/CE LISTING

f. _____
SPECIALTY

g. _____
SPECIALTY LICENSE # (IF APPLICABLE) | DATE COMPLETED

8. PLEASE ENCLOSE A CURRENT COPY OF YOUR CV, IF AVAILABLE.

9. Board Certification: In what area(s) if any are you Board Certified?

_____ DATE: ____/____/____ ☐ N/A
BOARD CERTIFIED | M D Y

10. Drug License: _____
DEA NUMBER

11. Anesthesia Permit #: _____

12. Have you completed an Advanced Education in General Dentistry (AEGD) residency program or any accredited post graduate specialty educational program in dentistry and/or anesthesia at an accredited dental or medical school in the United States?..... ☐ Yes ☐ No

If "Yes", submit a copy of your current certificate.

13. Have you completed a post graduate course in anesthesia or conscious sedation from an accredited dental or medical school or other facility accredited for such courses by a recognized accrediting agency in the health care field?..... ☐ Yes ☐ No

If "Yes", submit a copy of your current certificate.

14. Have you taken a maxi-course or clinical hands-on continuing education course(s) for implant treatment? ..... ☐ Yes ☐ No

If "Yes", submit a copy of your current certificate.

15. Have you participated in a risk management program within the last 3 years? ..... ☐ Yes ☐ No

If "Yes", provide copy of certificate or course name and description.

If "No", would you like additional risk management information?

..... ☐ Yes ☐ No

16. Please describe current training in cardiac life support and other emergency medical care. Indicate the renewal date.

_____

_____

_____

_____ DATE: ____ /____ /____
M D Y

D. YOUR PRACTICE

1. Do you own your own practice? ..... ☐ Yes ☐ No

If "Yes", please attach a copy of your practice letterhead. If no, skip to Question 2.

a. _____
NAME OF BUSINESS

b. _____
CORPORATE NPI NUMBER

c. Are you incorporated?..... ☐ Yes ☐ No

If "Yes", date of incorporation _____ /_____ /_____

d. How many locations are in your practice?_____

e. Is this office managed by a dental management corporation? ..... ☐ Yes ☐ No

f. How many dental units does your office have? _____

g. Do you refer overdue patient accounts to a collection agency? ..... ☐ Yes ☐ No

If "Yes", how many accounts have you referred in the last year?_____

h. Do you or your corporation employ other dentist(s)? .... ☐ Yes ☐ No

If "Yes", how many dentists in practice?_____

Also, if "Yes", please provide a copy of the current professional liability declarations page or Dentist's Advantage policy number for each employed dentist.

i. Are other dentists working under a written contract with you and/or your corporation to provide services?..... ☐ Yes ☐ No

If "Yes", please provide a copy of the current professional liability declarations page for each dentist under contract.

j. Are other non-employed dentists working with you or your corporation without a written contract? ..... ☐ Yes ☐ No

k. Do you share, lease or own office space with another dentist? ..... ☐ Yes ☐ No

l. Is your practice a partnership?..... ☐ Yes ☐ No

If "Yes", please provide a copy of the current professional liability declarations page for each partner dentist.

m. Do you employ or contract any dental auxiliary or other office staff?..... ☐ Yes ☐ No

If "Yes", please provide the number of each employed:

_____ Dental Assistants _____ Dental Hygienists

_____ Nurse Anesthetists _____ Lab Technicians

_____ Other Office Staff

n. Do you have a dental assistant or hygienist present when treating patients? ..... ☐ Yes ☐ No

2. Are you a salaried employee of another dentist? ..... ☐ Yes ☐ No

3. Are you providing services under contract to another dentist? ..... ☐ Yes ☐ No

4. Are you associated with another dentist? ..... ☐ Yes ☐ No

If you answered "Yes" to any item in 2-4 above, please provide a copy of the practitioner's current professional liability declarations page.

5. Except for referrals to specialists, are you solely responsible for the treatment and follow up care for the patients you treat?..... ☐ Yes ☐ No

6. Do you have a physician or surgeon in your practice?..... ☐ Yes ☐ No

7. Do you serve as a faculty member at a dental school?..... ☐ Yes ☐ No

If "Yes", how many hours per day? _____

If "Yes", you may be eligible for a premium discount. Please include a letter from the school acknowledging your position.

a. Does the school provide you with insurance?..... ☐ Yes ☐ No

b. What is the name of the School?

_____

BASED UPON YOUR ANSWERS TO QUESTIONS 8 THROUGH 15 BELOW COMPLETION OF A SUPPLEMENTAL APPLICATION MAY BE REQUIRED.

8. Please provide the percentages (based on number of procedures) of your practice which fall into the following CDT codes (must total 100%)*:

Dental Procedure	CDT Code	%
Diagnostic	D0100 – D0999	
Preventive	D1000 – D1999	
Restorative	D2000 – D2999	
Endodontics	D3000 – D3999	
Periodontics	D4000 – D4999	
Prosthodontics (Removable)	D5000 – D5899	
Maxillofacial Prosthetics	D5900 – D5999	
Implant Services	D6000 – D6199	
Prosthodontics (Fixed)	D6200 – D6999	
Oral and Maxillofacial Surgery	D7000 – D7999	
Orthodontics	D8000 – D8999	
Adjunctive General Services	D9000 – D9999	

*If you are performing any procedures not included in the chart above, please provide details including the percentage of time spent on those activities based on the number of procedures:

_____

_____

9. Please confirm if you currently perform any of the following dental techniques or procedures:

a. Sargenti, RC-2B, N2 ..... ☐ Yes ☐ No

b. Radiation therapy ..... ☐ Yes ☐ No

c. Laser (Excluding curing composites and whitening) ..... ☐ Yes ☐ No

If "Yes" please describe the type of laser used and the procedures that are performed on a separate sheet of practice letterhead.

d. Botox injections (other than treating facial spasms, TMJ pain dysfunction and muscular pain) ..... ☐ Yes ☐ No

e. Derma fillers ..... ☐ Yes ☐ No

10. Do you examine your patients for oral cancer and/or use diagnostic or screening techniques for detecting oral cancer? ..... ☐ Yes ☐ No

If "Yes", please describe the procedures you use in your practice:

_____

_____

11. Do you offer any services for the purpose of appearance or skin enhancement, hair removal or replacement, personal grooming or therapy or other cosmetic purposes? ..... ☐ Yes ☐ No

If "Yes", please explain:

_____

_____

12. Do you render to your patients any service, treatment, advice or instruction for the purpose of weight management?..... ☐ Yes ☐ No

If "Yes", please explain:

_____

_____

13. How many complex cases do you perform each year in which the fees total more than $20,000?_____

14. Do you perform full mouth reconstructions? (affecting more than 90% of the teeth in the mouth) ..... ☐ Yes ☐ No

If "Yes", how many do you perform each year? _____

15. Please indicate below if you perform any surgical procedures. If "Yes," please estimate the percentage each surgical procedure bears to your total practice (based on numbers of procedures) on an annual basis.

Procedure	**Estimated %**
Implants	_____
Extractions of bony impacted, or partially bony impacted teeth.....	_____
Other dental cosmetic procedures (excluding biopsies, but including TMJ)	_____
Periodontal surgery	_____
Other surgery, including non-dental procedures	_____

_____

(Describe)

E. OFFICE PROCEDURES

1. Please confirm your average number of patients per week _____, and average number of practice hours per week _____.

If you are working less than 20 hours per week you may qualify for a part-time discount. Please explain on your letterhead a.) the reason for your part-time status, and b.) who will handle emergencies when you are out of the office?

2. What is your patient mix? Adults _____ Children _____.

3. Is emergency resuscitation equipment – oxygen, AED, pulse oximeter, and a basic emergency kit available on site? ..... ☐ Yes ☐ No

If "Yes", are all designated staff in the operatory trained in its use? ..... ☐ Yes ☐ No

INFORMED CONSENT

4. What type of Informed Consent do you use? ☐ Oral ☐ Written ☐ Both ☐ None

a. If oral, is chart noted, dated and initialed by the patient? ☐ Yes ☐ No ☐ Not applicable

b. If Informed Consent is written, is it witnessed? ..... ☐ Yes ☐ No
(Please provide a sample copy of your Informed Consent Form)

c. Is Informed Consent obtained at the start of each procedure? ..... ☐ Yes ☐ No

MEDICAL HISTORY

5. Do you obtain a complete patient medical history? ☐ Yes ☐ No
(Please provide a sample copy of your Medical History Form)

6. How often do you or your staff update patient histories? ☐ Each Visit ☐ Occasionally ☐ No Policy

If occasionally, what is your procedure?_____

PERIODONTICS

7. Do you examine all new patients for the presence of periodontal disease? ☐ Yes ☐ No
At every recall visit? ☐ Yes ☐ No

8. Do you chart pocket depths? ☐ Yes ☐ No
If "Yes", please indicate how often_____

F. ANESTHETICS AND ANALGESIA

Please describe your use of anesthetics and types of analgesia in your practice as indicated below.
For purposes of this application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.

1. Do you use conscience sedation? ☐ Yes ☐ No

2. Is oral conscious medication used? ☐ Yes ☐ No

3. Is IV, IM, sub-cutaneous or other injected forms of conscious sedation used? ☐ Yes ☐ No

If "Yes", are you administering the sedation and performing the dental procedure? ☐ Yes ☐ No ☐ Not applicable

4. Are you treating patients who are under general anesthesia (deep sedation)? ☐ Yes ☐ No

If "Yes" are you administering the anesthesia and performing the dental procedure? ☐ Yes ☐ No ☐ Not applicable

5. If you answered "Yes" to any of the questions 1 – 4 above:

Are the procedures performed in a dental office? ☐ Yes ☐ No

If "No" please indicate location_____

6. If you answered number 5 above "Yes", please indicate below or on your letterhead (if necessary) the type of agents used for each "Yes" answer, the frequency of use and by whom (yourself, MD Anesthetist, RN Anesthetist or other) the anesthesia is administered.

AGENTS	MODALITY	FREQUENCY	ADMINISTERED BY
AGENTS	MODALITY	FREQUENCY	ADMINISTERED BY

7. Do you provide treatment to any patient who has been sedated with chloral hydrate? ☐ Yes ☐ No

G. OTHER EXPOSURE INFORMATION

1. Do you own or operate a dental laboratory? ☐ Yes ☐ No
If "Yes", please estimate percentage of work applicable to your own patients_____%

2. Do you own, offer or operate any other business enterprise, either in conjunction with your practice or not? (e.g. spa services, consulting services, etc.) ☐ Yes ☐ No
If "Yes", please describe:

_____

_____

3. Are you currently under a contractual agreement where you have agreed to provide services to others? ☐ Yes ☐ No

Please identify parties to the contract and describe services:

_____

_____

_____

4. Have you ever been denied membership or participation in any health maintenance or similar organization? ☐ Yes ☐ No

5. Are you currently under a contractual agreement to hold any other party harmless for services you perform? ☐ Yes ☐ No

6. Please identify any additional insureds requested to be named on the policy applied for:

_____
LESSOR OF LEASED PREMISES

_____
LESSOR OF LEASED EQUIPMENT

_____
OWNER OF PREDECESSOR PRACTICE

_____

_____
OTHER, PLEASE EXPLAIN

H. CLAIMS AND EXPERIENCE INFORMATION

If you answer "Yes" to questions 1, 2 or 3 below, please provide on your letterhead the information requested below for each claim.

(a) Claimant's Name,
(b) Date of Alleged Error,
(c) Name of Insurer,
(d) If claim is closed, the total amount paid,
(e) If claim is pending, the claimant's demand amount and insurer's loss reserve,
(f) Description of claim including alleged error according to the claimant and your description of your treatment and extent of injury sustained.

1. Has there ever been a malpractice claim or suit filed against you or your corporation/partnership/association? ☐ Yes ☐ No

2. Do you know of any facts, circumstances, injuries, damages, acts, errors or omissions which may result in a malpractice claim against you, other dentists employed by you or your auxiliary staff? ☐ Yes ☐ No

If "Yes", have these been reported to a professional liability insurer? ☐ Yes ☐ No

3. Have you ever utilized Peer Review in an attempt to settle a patient complaint? ☐ Yes ☐ No

4. Please answer the following. For any "Yes" answers, please explain on your letterhead.

a. Have you ever had any disciplinary action, restriction, suspension, probation or revocation of a license to practice dentistry? ☐ Yes ☐ No

b. Have you ever had any disciplinary action, restriction, suspension, probation or revocation of a license to administer or prescribe drugs? ☐ Yes ☐ No

c. Have you ever had any restriction, suspension, probation or revocation of privileges in any hospital or other health care facility? ☐ Yes ☐ No

d. Have you ever had any personal health problems (including alcoholism, drug addiction, mental illness or communicable disease)? ☐ Yes ☐ No

e. Have you ever had complaints filed against you involving the administration of Medicare/Medicaid or patient insurance? ☐ Yes ☐ No

f. Other than traffic violations, have you ever been convicted of a crime? ☐ Yes ☐ No

g. Have you ever been declined or cancelled for any Dental Professional Liability Insurance? (Missouri residents: Do not respond) ☐ Yes ☐ No

h. Have you ever been denied membership or participation in any health maintenance or similar organization?. ☐ Yes ☐ No

If you are applying for Business Liability Coverage in addition to Professional Liability Coverage, please answer the following questions.

5. Have any claims been made against you in the last five years arising out of:

a. Liability for your office premises including damages from water or fire to leased premises? ☐ Yes ☐ No

b. Liability arising out of the use of automobiles not owned by you? ☐ Yes ☐ No

c. Claims for benefits for your employees arising out of your administration of those benefits? ☐ Yes ☐ No

d. Allegations of sexual harassment, unfair discrimination or other wrongful employment practices? ☐ Yes ☐ No

e. Violation of any rule or law regulating the disposal of medical wastes? ☐ Yes ☐ No

Please read the following Representations carefully and sign and date this application on Page 8. Applications can not be accepted without a valid signature.

Representations

By signing this application you, the applicant, agree with us, the Company that:

A. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have divulged any and all such situations in Section H. 1 and H. 2 of this application; and

B. The application and attachments, and all of the statements and answers given therein are:
   1. Accurate and complete to the best of your knowledge;
   2. Representations you are making on behalf of all persons and entities proposed to be covered;
   3. A material inducement to us to provide a proposal for insurance and any policy issued by us is issued in specific reliance upon these representations; and

C. You agree to report to us in writing any material change in your operations, conditions, or answers provided in this application that may occur or be discovered after the completion date of the application and before the effective date of the policy. On receipt of such written notice, we have the right to modify or withdraw any proposal for insurance we have offered, at our sole discretion.

D. You authorize us, our agents and representatives to secure claims information from your current and previous insurance carriers.

E. The discovery of any fraud, intentional concealment, or misrepresentation of material fact will render this Policy, if issued, void at inception.

F. If this application is for Claims Made coverage, only claims first made against you and reported to us during the policy period or any applicable extended reporting period are covered, subject to the policy provisions.

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: 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.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO ANY INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE 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 REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: 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 FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: 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 IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: 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.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: 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 (365:15-1-10, 36§3613.1).

NOTICE TO OREGON APPLICANTS: 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE

Signing of the application does not bind you or us.

SIGNED (APPLICANT)

DATE

TITLE (MUST BE SIGNED BY AUTHORIZED OFFICER)

PRODUCER

LICENSE NUMBER

ADDRESS

PLEASE MAKE SURE THE FOLLOWING ITEMS ARE INCLUDED (as applicable):

- ☐ A copy of your current declarations page (if new applicant)
- ☐ If you are currently insured, a copy of a current loss run from your current insurance carrier
- ☐ A copy of your CV
- ☐ A copy of your Practice Letterhead
- ☐ Certificate of Insurance or copies of declaration pages for all independent contractors and/or employee Dentists
- ☐ A copy of Health History Form used in your practice
- ☐ Copies of all Consent for treatment forms (if new applicant)
- ☐ Copy of your license
- ☐ Copy of your conscious sedation permit or license if applicable
- ☐ Copies of certificates for implant courses taken
- ☐ Copies of certificates for risk management courses taken
- ☐ Current letter of faculty appointment
- ☐ Copy of certificates for laser courses taken
- ☐ Copy of all correspondence, orders, and stipulations you received from Dental Board
- ☐ If you have a claim(s), include the supplemental claim form(s) for each claim
- ☐ Copies of proof of coverage for employer, hospital, clinic, or dental school