

Dentists Professional Liability Application

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA
2595 Interstate Drive, Suite 103, Harrisburg, PA 17110
Administrative Offices: 175 Water Street, 18th Floor, 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 # _____

DDS _____

DMD _____

1. _____
FIRST NAME MIDDLE INITIAL LAST NAME

2. _____
NATIONAL PROVIDER ID #

3. _____
NAME OF PRACTICE

4. _____
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. (_____) BUSINESS PHONE NUMBER
b. (_____) RESIDENCE PHONE NUMBER
c. _____ E-MAIL ADDRESS
d. (_____) FAX NUMBER
e. (_____) CELL PHONE NUMBER
f. _____ 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

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

- 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,	(d) If claim is closed, the total amount paid,	(f) Description of claim including alleged error
(b) Date of Alleged Error,	(e) If claim is pending, the claimant's demand	according to the claimant and your description
(c) Name of Insurer,	amount and insurer's loss reserve,	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 AN 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 OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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 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.

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.

SIGNATURE

Signing of the application does not bind you or us.

SIGNED (APPLICANT)

PRODUCER

DATE

LICENSE NUMBER

TITLE (MUST BE SIGNED BY AUTHORIZED OFFICER)

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**