Requested Effective Date __ - __ - ____ 12:01 AM

Policy Number: ____________
Company Use Only

The Medical Protective Company

Dental Individual Professional Liability Insurance Application

For Faster Service, Please Enter Your Application online at WWW.MEDICALPROTECTIVE.COM

I. GENERAL INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

Please print legibly, policy is based on readability of your name. Please answer all questions; if a question is not applicable, state "N/A"

A.

LAST NAME

FIRST NAME (FULL)

MIDDLE NAME | SUFFIX | DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY NUMBER

Degree: ☐ *DDS* ☐ *DMD* ☐ *MD* ☐ *DO* ☐ *BDS*

B. OFFICE LOCATIONS WHERE YOU PRACTICE (PLEASE LIST PRINCIPAL LOCATION FIRST)

(Combined Percentage of Practice for all Office and Hospital locations must total 100%)

1.

% Of Practice | NUMBER & STREET

SUITE | ADDRESS 2

CITY | STATE | ZIP CODE

COUNTY

2.

% Of Practice | NUMBER & STREET

SUITE | ADDRESS 2

CITY | STATE | ZIP CODE

COUNTY

C. HOSPITALS WHERE YOU PRACTICE (PLEASE LIST PRINCIPAL LOCATION FIRST)

(Combined Percentage of Practice for all Office and Hospital locations must total 100%)

1.

% Of Practice | HOSPITAL NAME

NUMBER & STREET

SUITE | ADDRESS 2

CITY | STATE | ZIP CODE

COUNTY

☐ ADMITTING ☐ NON-ADMITTING ☐ N/A If Non-Admitting, please explain: ____________

I. GENERAL INFORMATION (continued)

If Additional Space is Needed, Please Use Supplemental Form

D. HOME ADDRESS

NUMBER & STREET

APARTMENT#

ADDRESS 2

CITY

STATE

ZIP CODE -

COUNTY

E. PREFERRED MAILING/BILLING ADDRESS

- [ ] OFFICE # (FROM SECTION I.B.) ____________
- [ ] HOME
- [ ] HOSPITAL # (FROM SECTION I. C.) ____________
- [ ] OTHER (PLEASE ENTER BELOW)

NUMBER & STREET

SUITE

CITY

STATE

ZIP CODE -

F. PREFERRED METHOD OF CONTACT

- [ ] E-MAIL
- [ ] BUSINESS FAX
- [ ] BUSINESS PHONE
- [ ] RESIDENCE PHONE

E-MAIL ADDRESS

BUSINESS FAX - -

BUSINESS PHONE - -

RESIDENCE PHONE - -

II. EDUCATIONAL BACKGROUND

If Additional Space is Needed, Please Use Supplemental Form

A. DENTAL SCHOOL

NAME OF SCHOOL

CITY

STATE

COUNTRY

DEGREE: GENERAL DENTISTRY

COMPLETED FROM MM - YYYY ***TO*** MM - YYYY

B. RESIDENCY, FELLOWSHIP OR UNIVERSITY/CLINICAL BASED TRAINING: LIST ALL TRAINING LOCATIONS.

(i.e., Residency Specialty Training, Anesthesia Residency Training, Fellowship, GPR, AEGD Military Rotation, etc.)

1.

NAME OF HOSPITAL/FACILITY

CITY

STATE

COUNTRY

SPECIALTY TYPE COMPLETED

COMPLETED FROM MM - YYYY ***TO*** MM - YYYY

II. EDUCATIONAL BACKGROUND (continued)

If Additional Space is Needed, Please Use Supplemental Form

B. RESIDENCY, FELLOWSHIP OR UNIVERSITY/CLINICAL BASED TRAINING: LIST ALL TRAINING LOCATIONS. (continued)
(i.e., Residency Specialty Training, Anesthesia Residency Training, Fellowship, GPR, AEGD Military Rotation, etc.)

2.

NAME OF HOSPITAL/FACILITY

CITY STATE COUNTRY

SPECIALTY TYPE COMPLETED

COMPLETED FROM - ***TO*** -
MM YYYY MM YYYY

C. HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? (i.e., Other Than Residency or Fellowship) YES NO

1.

NAME OF HOSPITAL/FACILITY

CITY STATE COUNTRY

SPECIALTY TYPE COMPLETED

COMPLETED FROM - ***TO*** -
MM YYYY MM YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN 6 MONTHS BETWEEN YOUR DENTAL SCHOOL, RESIDENCY, FELLOWSHIP OR FIRST TIME IN PRIVATE PRACTICE: ______

E. IF YOU ARE CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM, PLEASE ENTER YOUR ANTICIPATED RESIDENCY/FELLOWSHIP ENDING DATE HERE: - -
MM DD YYYY

(Your Medical Protective Company policy may be issued for less than one year in order to have the policy expiration month and day equal the residency ending month and day.)

F. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME? YES NO

G. HAVE YOU PARTICIPATED IN ANY CONTINUING DENTAL EDUCATION WITHIN THE LAST TWO YEARS? YES NO

If yes, how many credit hours?

H. HAVE YOU COMPLETED A RISK MANAGEMENT EDUCATION COURSE WITHIN THE LAST TWELVE (12) MONTHS? YES NO

I. IF YOU ANSWERED YES, DID THE COURSE PROVIDE ALL OF THE FOLLOWING: YES NO

- A minimum of three continuing dental education (CDE) HOURS?
- Sponsored by an approved national/regional Dental Educational sponsor, and strictly adhere to a risk management (loss prevention) curriculum?
- Are the CDE hours through an approved regional dental sponsor?

III. PRACTICE INFORMATION

If Additional Space Is Needed, Please Use Supplemental Form

A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER DENTISTS OR ORGANIZATIONS WHO RENDER DENTAL/MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? ☐ YES ☐ NO

(If this is covered by another professional liability insurance policy, complete question 9 in section VII.)

If Yes, Which State(S): ______________________________

____

B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE DENTISTRY:

(Exclude state abbreviation)

Please check the appropriate box to indicate the status of your license

			Active	Inactive	Temporary	Pending
1. STATE ☐☐	*LICENSE #* ☐☐☐☐☐☐☐☐☐☐		☐	☐	☐	☐
2. STATE ☐☐	*LICENSE #* ☐☐☐☐☐☐☐☐☐☐		☐	☐	☐	☐
3. STATE ☐☐	*LICENSE #* ☐☐☐☐☐☐☐☐☐☐		☐	☐	☐	☐

4. DEA LICENSE? ☐ YES ☐ NO If no DEA License, why? ______________________________

C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING

If no previous location(s), please indicate your earliest start date at your current location(s): ☐☐ - ☐☐☐☐
MM YYYY

1. ______________________________
NAME OF PRACTICE

______________________________ ____ ______________________________
CITY STATE COUNTRY

______________________________ ***FROM*** ☐☐ - ☐☐☐☐ ***TO*** ☐☐ - ☐☐☐☐
SPECIALTY MM YYYY MM YYYY

2. ______________________________
NAME OF PRACTICE

______________________________ ____ ______________________________
CITY STATE COUNTRY

______________________________ ***FROM*** ☐☐ - ☐☐☐☐ ***TO*** ☐☐ - ☐☐☐☐
SPECIALTY MM YYYY MM YYYY

3. ______________________________
NAME OF PRACTICE

______________________________ ____ ______________________________
CITY STATE COUNTRY

______________________________ ***FROM*** ☐☐ - ☐☐☐☐ ***TO*** ☐☐ - ☐☐☐☐
SPECIALTY MM YYYY MM YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN ONE MONTH BETWEEN PRACTICE LOCATIONS: ______________________________

____

____

E. TO WHICH STATE/LOCAL DENTAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG? ______________________________

____

____

If none, please explain: ______________________________

____

____

IV. RATING INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. WHAT IS YOUR PRESENT SPECIALTY?

- [ ] General Dentist
- [ ] Orthodontist
- [ ] Pediatric Dentist
- [ ] Endodontist
- [ ] Periodontist
- [ ] Prosthodontist
- [ ] Oral Pathologist
- [ ] Dental Anesthesiologist
- [ ] Oral & Maxillofacial Surgeon
  - [ ] Dual Degree (Dental/Medical)
- [ ] Pain Management (Please explain): ____________
- [ ] Other: ____________
- [ ] Board Certified? (Date): MM - YYYY
  Type: ____________

B. PLEASE INDICATE THE AVERAGE WEEKLY HOURS OR PATIENTS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE. (If you practice in multiple states, please identify the following information for each state.)

PATIENTS SEEN PER WEEK ____ HOURS PER WEEK ____ NEW WALK-IN PATIENTS PER WEEK ____

C. PLEASE CHECK PROCEDURES YOU CURRENTLY OR WILL PERFORM IN YOUR PRACTICE: *(Please check all that apply)*

- [ ] Orthodontic Full Mouth Banding
  Year you began these procedures: YYYY
- [ ] Surgical/Anchor portion of Dental Implants
  Year you began these procedures: YYYY
- [ ] Prosthesis/Abutment
  Year you began these procedures: YYYY
- [ ] Third Molar Extractions (CPT/CDT Codes)
  - [ ] Erupted (D7110, D7120)
    Year you began these procedures: YYYY
  - [ ] Partial Impaction (D7210, D7220, D7230)
    Year you began these procedures: YYYY
  - [ ] Fully Impacted (D7240, D7241, D7250)
    Year you began these procedures: YYYY

IMPLANT TYPE:

- [ ] Endosteal
- [ ] Mini Implants
- [ ] Subperiosteal
- [ ] Mandibular Multi-quadrant - Ramus Frame
- [ ] Other Implant Types: ____________

- [ ] Sargenti Root Canal method utilizing N2 or similar paste.
- [ ] Sleep Apnea Therapy
  Do you treat only after physician referral? [ ] YES [ ] NO
- [ ] Molar Endodontics

- [ ] Nerve Grafts
- [ ] Sinus Lifts
- [ ] Trigger Point Injections
- [ ] Botox Injections
- [ ] Bleaching/Whitening agents
- [ ] Permanent Eye Liner/Lip Tattooing
- [ ] Parotid Gland Surgery
- [ ] Management of Malignant Lesions
- [ ] Orthognathic Surgery
- [ ] Face Lifts
- [ ] Skin Peels
- [ ] Cleft Lip and Palate Surgery
- [ ] Rhinoplasty
- [ ] TMJ Surgery
  - [ ] TMJ Arthroscopy
  - [ ] Vitec Implant
  - [ ] TMJ Implants
  - [ ] Reconstructive Surgery
- [ ] Alternative (holistic) Dentistry/Medicine
  Please Explain: ____________
- [ ] Spa Services
  Please Explain: ____________
- [ ] Obesity/Weight Control Treatment
  Please Explain: ____________
- [ ] Other Dental Techniques that will help
  Medical Protective better understand any special circumstances concerning your practice
  List Procedures: ____________

D. INDICATE THE PERCENT OF YOUR PRACTICE DEVOTED TO THE FOLLOWING PROCEDURES: *(Does Not have to equal 100%)*

- ____ % Dentures Including: (check all that apply): [ ] Same Day or Economy Dentures [ ] Replacement Dentures [ ] Denture Relines
- ____ % Oral Surgery (extractions, removal of cysts, etc)
- ____ % Elective facial cosmetic surgery/procedures (including rhinoplasty, face-lifts, skin grafts, botox, collagen, etc.)
- ____ % Reconstructive Cosmetic Procedures (i.e., cancerous lesion, facial reconstruction, cleft lip/palate, etc)
- ____ % Procedures performed outside of the Oral and Maxillofacial Region (except bone harvesting procedures).
  Please explain: ____________

IV. RATING INFORMATION (continued) — *If Additional Space is Needed, Please Use Supplemental Form*

E. HAVE YOU DISCONTINUED ANY PROCEDURES? ☐ YES ☐ NO

Which procedure(s)? ______________________________

When: ☐☐ - ☐☐☐☐ (MM YYYY) Why? ______________________________

F. HAVE YOU ADDED ANY NEW SERVICES, PROCEDURES OR TREATMENTS TO YOUR PRACTICE IN THE LAST 12 (TWELVE) MONTHS? ☐ YES ☐ NO

Which procedure(s)? ______________________________

When: ☐☐ - ☐☐☐☐ (MM YYYY) Why? ______________________________

G. EXCEPT FOR ANESTHESIA PROCEDURES REFERRED TO DENTAL ANESTHESIOLOGISTS OR PROCEDURES REFERRED BY SPECIALISTS BACK TO THE PRIMARY DENTAL CARE PROVIDER, DO YOU:

1. Refer patients to other dentists that are not licensed as dental "specialists" for the procedures being performed? ☐ YES ☐ NO

If yes, are the procedures performed in your office? ☐ YES ☐ NO

If no, where: ______________________________

Please list the procedures referred to non-specialists: ______________________________

2. If you are not licensed as a dental specialist, do you accept referrals from other dentists? ☐ YES ☐ NO

If yes, are the procedures performed in your office? ☐ YES ☐ NO

If no, where: ______________________________

Please list the procedures referred to you: ______________________________

V. BUSINESS PRACTICES — *If Additional Space is Needed, Please Use Supplemental Form*

A. PLEASE INDICATE WITH AN (X) EACH OF THE PROCEDURES YOU PERFORM, TRAINING AND WHETHER YOU OBTAIN INFORMED CONSENT FOR EACH OF THE PROCEDURES YOU CHECKED

Procedure	Do you obtain informed consent?	40 CE's	Residency	None
☐ Full Mouth Banding Orthodontics	☐ YES ☐ NO	☐ YES	☐ YES	☐ NO
☐ Dental Implants (Anchor portion only)	☐ YES ☐ NO	☐ YES	☐ YES	☐ NO
☐ Partial Impacted Third Molar Extractions	☐ YES ☐ NO	☐ YES	☐ YES	☐ NO
☐ Fully Impacted Third Molar Extractions	☐ YES ☐ NO	☐ YES	☐ YES	☐ NO
☐ Conscious Sedation	☐ YES ☐ NO	☐ YES	☐ YES	☐ NO
☐ General Anesthesia Sedation	☐ YES ☐ NO	☐ YES	☐ YES	☐ NO
☐ Facial Cosmetic Surgery	☐ YES ☐ NO	☐ YES	☐ YES	☐ NO
☐ Other (Please Explain): ____________	☐ YES ☐ NO	☐ YES	☐ YES	☐ NO

Residencies must be documented in Section II. (Educational Background)

☐ ***I do not perform these procedures***

B. IF YOU ANSWERED "NONE" TO THE CONTINUING EDUCATION QUESTIONS, PLEASE EXPLAIN YOUR ADDITIONAL EXPERIENCE FOR EACH PROCEDURE YOU PERFORM: ______________________________

VI. ANESTHESIA INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. AS DEFINED BELOW, PLEASE "X" IF YOU, AN EMPLOYEE OR INDEPENDENT CONTRACTOR TREAT PATIENTS UNDER:

- ☐ ***Please "X" here if this section does not apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar Non-Scheduled Drug) or nitrous oxide only. Please continue to Section VII.***
- ☐ ***CONSCIOUS SEDATION UTILIZING ADA CODE D09241 and D09242- (Excluding Nitrous Oxide)*** A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.
  - ☐ Oral ☐ IM/IV
- ☐ ***GENERAL ANESTHESIA UTILIZING ADA CODE D09220- (To include deep sedation)*** A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

B. IF YOU PERFORM CONSCIOUS SEDATION OR GENERAL ANESTHESIA, DO YOU PERFORM ANESTHESIA FOR MEDICAL PROCEDURES? ☐ YES ☐ NO

C. IF YOU PERFORM CONSCIOUS SEDATION OR GENERAL ANESTHESIA, DO YOU PROVIDE SEDATION FOR PATIENTS OTHER THAN YOUR OWN OR IN OTHER DENTAL OFFICES? ☐ YES ☐ NO

D. PLEASE INDICATE WHO ADMINISTERS CONSCIOUS SEDATION:

- ☐ I DO
- ☐ Oral Surgeon
- ☐ Nurse Anesthetist/CRNA
- ☐ Other (specify): ____________
- ☐ RN/LPN
- ☐ Dentist Anesthesiologist
- ☐ MD/DO Anesthesiologist

WHERE IS CONSCIOUS SEDATION PERFORMED? (Check all that apply)

- ☐ In office
- ☐ Hospital
- ☐ Licensed Surgical Center
- ☐ Other (specify): ____________

E. PLEASE INDICATE WHO ADMINISTERS GENERAL ANESTHESIA:

- ☐ I DO
- ☐ Oral Surgeon
- ☐ Nurse Anesthetist/CRNA
- ☐ Other (specify): ____________
- ☐ RN/LPN
- ☐ Dentist Anesthesiologist
- ☐ MD/DO Anesthesiologist

WHERE IS GENERAL ANESTHESIA PERFORMED ? (Check all that apply)

- ☐ In office
- ☐ Hospital
- ☐ Licensed Surgical Center
- ☐ Other (specify): ____________

F. DO YOU PRESCRIBE BENZODIAZEPINE DRUG CLASS ORAL SEDATION AGENTS (HALCION, TRIAZOLAM, ATIVAN, VALIUM OR SIMILAR ANESTHETIC AGENT) FOR USE PRIOR TO AND/OR DURING THE PATIENTS SCHEDULED APPOINTMENT? ☐ YES ☐ NO

1. If yes, do you prescribe to:

- ☐ Adults
- ☐ Children

2. If yes, do you prescribe:

- ☐ One single dose the day of appointment
- ☐ Multiple doses:

If multiple doses is checked, are the dosages prescribed: ***(Please check all that apply)***

☐ Prior to and during the scheduled appointment ☐ Prior to the scheduled appointment ☐ During the appointment

G. HOW OFTEN DO YOU UPDATE HEALTH HISTORIES? ☐ YES ☐ NO

- ☐ Every ______ Month(s)
- ☐ Every Patient Visit
- ☐ Anytime invasive procedures are performed
- ☐ Other (please explain): ____________

H. IS YOUR OFFICE CERTIFIED FOR GENERAL ANESTHESIA BY A STATE ORGANIZATION? ☐ YES ☐ NO

Date of Issuance? ☐☐ - ☐☐☐☐
MM YYYY

I. IF CONSCIOUS OR GENERAL ANESTHESIA SEDATION IS PERFORMED OUTSIDE OF A HOSPITAL, HOW OFTEN DO YOU AND YOUR STAFF PARTICIPATE IN SIMULATED EMERGENCY TRAINING?

Every: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: ____________

J. ARE YOU OR THE INDIVIDUAL ADMINISTERING THE SEDATION CERTIFIED IN ONE OR MORE OF THE FOLLOWING? ☐ YES ☐ NO

If yes, please "x" the boxes that apply: ☐ CPR ☐ ACLS ☐ ATLS ☐ PALS

VI. ANESTHESIA INFORMATION (continued) — *If Additional Space is Needed, Please Use Supplemental Form*

K. DO YOU UTILIZE THE FOLLOWING EQUIPMENT: (Please "X" equipment used) If you are a host Dentist please verify whether you or any anesthesia provider utilized outside of a hospital setting will supply the following equipment:

(Checking the box indicates this equipment will be available during all anesthesia procedures performed outside a hospital setting)

- ☐ Fail safe mechanisms on anesthesia machines
- ☐ Basic Airway Equipment
  - ☐ Full Face Mask Resuscitator
  - ☐ Oral and Nasopharyngeal Airways
  - ☐ Endotracheal Tubes (Adult/Child size)
  - ☐ Laryngoscope
- ☐ Sphygmomanometer/Stethoscope
- ☐ Electrocardiographic Monitoring Equipment
- ☐ Pulse Oximeter
- ☐ CO_2 Monitor
- ☐ Internal/External Temperature Monitor
- ☐ Tracheostomy/Coniotomy Equipment
- ☐ Portable Suction
- ☐ Capnography
- ☐ Auxiliary Lighting
- ☐ Emergency Pharmaceutical Kit
- ☐ Direct Current Defibrillator

L. IF YOU ARE A HOST DENTIST, HAVE YOU AND WILL YOU ENSURE THAT ALL ANESTHESIA PROVIDERS PROVIDING SERVICES TO YOUR PATIENTS HAVE:

1. The equipment you indicated above? ☐ YES ☐ NO
2. Ensure the provider has a minimum of a two year anesthesia residency? ☐ YES ☐ NO
3. If your anesthesia provider is a CRNA, are they supervised on site by a doctor with a minimum two year anesthesia residency or greater? ☐ YES ☐ NO
4. Professional liability limits equal to or greater than your policy limits? ☐ YES ☐ NO
5. A valid license in your state of practice? ☐ YES ☐ NO

VII. ADDITIONAL PROFESSIONAL INFORMATION — *If Additional Space is Needed, Please Use Supplemental Form*

(If you are covered by other insurance for this activity, please complete section VII. Question 9.)

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM

1. ***Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?*** ☐ YES ☐ NO
   If yes, include a copy of the indemnification agreement provided by the pharmaceutical company.
   (If you are covered by other insurance for this activity, please complete section VII. Question 9.)
2. ***Do you treat or review treatment of federal prison inmates?*** ☐ YES ☐ NO
   If yes, please explain: ______________________________
   (If you are covered by other insurance for this activity, please complete section VII. Question 9.)
3. ***Do you treat non-federal prison inmates?*** ☐ YES ☐ NO
   If yes, what percentage of your practice is devoted to treating non-federal prison inmates? ___ %
   Does this facility have a law library? ☐ YES ☐ NO
   (If you are covered by other insurance for this activity, please complete section VII. Question 9.)
4. ***Do you use a collection agency which has the authority to file collection suits without your knowledge?*** ☐ YES ☐ NO
   If yes, please explain: ______________________________
5. ***Have you had involvement in the design, manufacture or distribution of any dental product(s) or written an instruction manual for products for use by other dentists?*** ☐ YES ☐ NO
   If yes, please explain and indicate the date(s): ______________________________ Date: __ - ____ (MM YYYY)
   (The professional liability coverage you are applying for does not provide product liability coverage.)
   Do you have separate coverage for this product liability exposure? ☐ YES ☐ NO
6. ***Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, dental license or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?*** ☐ YES ☐ NO
   If yes, please explain and indicate the date(s): ______________________________ Date: __ - ____ (MM YYYY)
7. ***Have you had any professional liability insurance declined, refused, canceled or non-renewed?*** ☐ YES ☐ NO
   If yes, please indicate the reason and date(s): ______________________________ Date: __ - ____ (MM YYYY)

VII. ADDITIONAL PROFESSIONAL INFORMATION (continued) — *If Additional Space is Needed, Please Use Supplemental Form*

(If you are covered by other insurance for this activity, please complete section VII. Question 9.) (continued)

8. Have you incurred or become aware of having a condition that impairs or could impair your ability to practice your dental profession? ☐ YES ☐ NO

(e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)

If ***Yes***, please state the condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, ***a statement from your treating physician attesting to your fitness to practice your specialty must accompany this application***. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type of Illness: ______________________

Duration of Illness: ☐☐ - ☐☐☐☐ *To* ☐☐ - ☐☐☐☐
MM YYYY MM YYYY

Treating Physician (Name & Address): ______________________

9. Will you be performing activities which will be covered by another professional liability policy? ☐ YES ☐ NO

If yes, are you considered an: ☐ Employee ☐ Independent Contractor ☐ Resident/Fellow ☐ Faculty

Practice name and location(s): ______________________

Name of Carrier: ______________________

10. Do you adhere to The Americans with Disabilities Act and treat patients with disabilities, including patients with HIV/AIDS? ☐ YES ☐ NO

VIII. PRACTICE ORGANIZATION INFORMATION — *If Additional Space is Needed, Please Use Supplemental Form*

A. PRACTICE ORGANIZATION:

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status

Note (1) : TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ *Solo Unincorporated/Sole Proprietor*

Entity Name:

Employment Status

☐ Sole Proprietor ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: ☐☐ - ☐☐☐☐
MM YYYY

If Other, please explain: ______________________

☐ *Solo Incorporated-No employed or contracted dentists*

Entity Name

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: ☐☐ - ☐☐☐☐
MM YYYY

If Other, please explain: ______________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Individual, Corporation or Partnership policy and group number, if known:

Policy #: ☐☐☐☐☐☐ Group #: ☐☐☐☐☐☐ Sub-Group#: ☐☐☐

If no, do you desire coverage for this entity? ☐ YES ☐ NO

If yes, do you have any employed or contracted dentist associated with your practice? ☐ YES *(1)* ☐ NO

If no, do you wish to share your individual policy limits with your solo corporation? ☐ YES ☐ NO

If yes, and you desire to share your individual policy limits, please initial here. ☐

Note: To qualify for shared limit solo corporation coverage, you must have no dentists employees or dentists independent contractors.

*** If you desire separate policy limits or you do not qualify for "solo corporation" coverage, please contact your agent to complete a separate entity application for consideration. ***

VIII. PRACTICE ORGANIZATION INFORMATION (continued) *If Additional Space is Needed, Please Use Supplemental Form*

A. PRACTICE ORGANIZATION: (continued)
Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status
Note (1) : TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ ***Multi-Shareholder Corporation, Partnership, Limited Liability Company***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ____________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

☐ ***Management Services Organization*** ☐ ***Dental Director***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ____________________

Does the entity provide Allied staff? ☐ YES ☐ NO

Is the entity responsible for billing practice fees? ☐ YES ☐ NO

Is the entity responsible for setting office protocols and referral standards? ☐ YES ☐ NO

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

☐ ***Hospital*** ☐ ***Industrial*** ☐ ***Government-Branch:*** ____________________

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ____________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

A. PRACTICE ORGANIZATION: (continued)

Please check the boxes that best describes your practice affiliation(s) and "x" applicable boxes under Employment Status

Note (1): TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ ***For Profit or Non-Profit Clinic*** ☐☐☐ ***% Of Practice*** ☐ ***Dental Director*** ☐ ***DDS Volunteer***

☐ ***No Fees or Revenue Paid to DDS***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ____________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

☐ ***Dental School-Are you :*** ☐ ***Faculty*** ☐ ***Clinical Supervision of Dental Students*** ☐ ***Student***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ____________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

☐ ***Dental Laboratory*** ☐ ***Your Patients Only*** ☐ ***For Use By other Dentists***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ____________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

VIII. PRACTICE ORGANIZATION INFORMATION (continued)

If Additional Space Is Needed, Please Use Supplemental Form

A. PRACTICE ORGANIZATION: (continued)

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status

Note (1) : TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ ***State Licensed Medical or Dental Surgical Center*** ☐ ***For Use By Other Dentists*** ☐ ***For Use By Other Physicians*** ☐ ***Dental Director*** ☐ ***Your Patients Only***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ______________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

☐ ***Mobile Dental Practice*** ☐ ***Dental Director***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ______________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

☐ ***Nursing Home Based Practice*** ☐ ***Dental Director***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ______________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

VIII. PRACTICE ORGANIZATION INFORMATION (continued) *If Additional Space Is Needed, Please Use Supplemental Form*

A. PRACTICE ORGANIZATION: (continued)

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status

Note (1) : TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ *Other-Please Explain:* ____________________

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ____________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company the Individual Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

B. PERCENTAGE OF FEES DERIVED FROM: (Please Indicate 0% if None)

Medicare/Medicaid reimbursement? %

Capitation reimbursement? %

Franchise Affiliation %

C. IF BUSINESS PURPOSE OF ENTITY IS OTHER THAN A DENTAL OFFICE PRACTICE, PLEASE EXPLAIN: ____________________

IX. LOSS INFORMATION (IMPORTANT PLEASE COMPLETE FULLY) *If Additional Space Is Needed, Please Use Supplemental Form*

Please complete the Claim/Suit Information Form, Section X, for each claim, potential claim or suit.

A. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? ☐ YES ☐ NO

If *yes*, how many?

If *yes*, have these been reported to your insurer? ☐ YES ☐ NO

B. Do you have knowledge of any incident or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim? ☐ YES ☐ NO

If *yes*, how many?

If *yes*, have these been reported to your insurer? ☐ YES ☐ NO

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE A COPY OF THE REPORT(S).

X. CLAIMS/SUIT INFORMATION FORM

(Please make copies if additional forms are needed)

If making additional copies, please enter applicant's name here: ____________________

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION

1. Patient/Claimant Information:

LAST NAME

FIRST NAME

AGE: ☐☐☐ Gender: ☐ Male ☐ Female

2. Date of treatment and/or surgery, which led to the allegations against you. MM - YYYY

3. Date claim/incident notice received. MM - YYYY

4. Date claim reported to prior insurer MM - YYYY

5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: ____________________

6. Disposition or current status of claim or suit: ☐ OPEN ☐ CLOSED

If Closed, Date of Closing/Settlement or award : MM - YYYY

7. Indicate case value established by carrier, if known: $ ___ , ___ , ___

8. Defending Insurance carrier name: ____________________
CARRIER NAME

9. Claim file number, if known: ____________________
CLAIM NUMBER

10. Was this matter closed with your consent? ☐ YES ☐ NO

Was a suit filed? ☐ YES ☐ NO

Was payment made? ☐ YES ☐ NO

If no, was claim or suit withdrawn? ☐ YES ☐ NO

If yes, indicate total amount of settlement or award: $ ___ , ___ , ___

Amount paid on your behalf: $ ___ , ___ , ___

11. Nature of allegations in the claim or suit:

Condition treated: ____________________

Treatment provided: ____________________

Alleged negligence: ____________________

Alleged injury: ____________________

12. Please provide a narrative description of the medical/dental facts:
(must include, but not limited to the type of treatment and/or surgery; your involvement): ____________________

XI. COVERAGE INFORMATION

If additional space is needed, please use supplemental form

A. List all previous professional liability insurers, dating back to completion date of formal training.

LIST CURRENT INSURER FIRST

1. ______________________ Insurer ☐ Claims Made ☐ Occurrence MM - DD - YYYY **to** MM - DD - YYYY
2. ______________________ Insurer ☐ Claims Made ☐ Occurrence MM - DD - YYYY **to** MM - DD - YYYY
3. ______________________ Insurer ☐ Claims Made ☐ Occurrence MM - DD - YYYY **to** MM - DD - YYYY

Please explain any gaps in coverage back to your start date of practice: ______________________

____

____

____

B. COVERAGE DESIRED

1. ☐ Occurrence
2. ☐ Claims-Made Coverage without Prior Acts Coverage
3. ☐ Claims-Made Coverage with Prior Acts Coverage ***(A copy of current declaration page showing current retroactive date must be attached)***
4. ☐ Convertible Claims-Made with Prior Acts Coverage

If 1 or 2 are selected from the above and the most recent prior coverage was issued on a Claims Made basis, please complete one of the following:

☐ An extended reporting endorsement (tail coverage) has been purchased (copy of tail is attached)

☐ An extended reporting endorsement has not and will not be purchased.

I ***will not*** purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am applying for with The Medical Protective Company if offered, will not provide prior acts coverage.

☐ ***Initial Here***

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between claims-made and occurrence coverage or the additional expense associated with an "extension contract" or "tail coverage."

C. REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M.

This date cannot be earlier than the expiration date of your current policy.

From: MM - DD - YYYY ***12:01 a.m.***

Annual policy terms will begin and end on the same month and day.

To: MM - DD - YYYY ***12:01 a.m.***

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:

(NOT REQUIRED FOR OCCURRENCE POLICIES OR CLAIMS-MADE WITHOUT PRIOR ACTS)

MM - DD - YYYY ***12:01 a.m.***

E. Limits Desired: ___ , ___ , ___ ***per occurrence/per claims-made***

___ , ___ , ___ ***annual aggregate***

Note: Requested limits may not be available from this company

XII. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my: ☐ Employer OR ☐ Named Third Party (Include Name&Address) ______________________

both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g. termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's Home Office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here ☐

Note: This assignment is continuous until we receive your written request to revoke your request. Third party finance company assignments must be renewed each year. Do not use this form to assign a third party finance company. Third party finance companies must submit a copy of your signed finance agreement, including your assignment of rights, with their request for cancellation.

XIII. STATE STATUTORY REQUIREMENT

NOTE: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here ☐

XIV. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, firm, or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS ***I WILL HAVE NO COVERAGE FOR ANY CLAIM*** UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Date Signed: __ __ - __ __ - __ __ __ __
MM DD YYYY

____
Signature

____
Print Name

When would you like your quote delivered? __ __ - __ __ - __ __ __ __
MM DD YYYY

FOR OFFICE USE ONLY Status: ☐ *Individual* ☐ *Entity Only* ☐ *Entity & Individual* ☐ *Group (Not Modular)* ☐ *CNBC*

PRODUCER NAME ______________________ *PRODUCER #* ______________________

PRODUCER CONTACT NAME ______________________ *TITLE (CSR, MM, etc)* ______________________

Preferred Method of Contact ☐ *E-MAIL* ☐ *FAX* ☐ *PHONE*

______________________ ___ - ___ - ____ ___ - ___ - ____

E-mail *Fax* *Phone*

Entity Name: ______________________

MedPro Corp. # ________ *MedPro Group #* ________ *MedPro Subgroup #* ________ *CMS #* ________

MedPro Policy # ________ *Modular Policy #* ________ ☐ New Group *Number of Insureds* ________

Billing: ☐ With Group ☐ As Individual *AT END OF POLICY PERIOD:* ☐ Renew ☐ Do Not Renew Why: ________

Comments: ______________________

XV. SUPPLEMENTAL FORM

(Attach a separate piece of paper if additional space is needed)

XV. SUPPLEMENTAL FORM CONTINUED *(Attach a separate piece of paper if additional space is needed)*