Requested Coverage Effective Date: ☐☐ - ☐☐ - ☐☐☐☐ 12:01 AM

Policy Number: ____________

The Medical Protective Company

Dental Entity (Corporation/Partnership) Professional Liability Insurance Application

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

APPLICATION INSTRUCTIONS

If additional space is needed, please use supplemental form

A. For coverage to exist, you must make separate application for any ancillary activity conducted by any separate entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture. If the entity is a corporation of any type, please attach a copy of Articles of Incorporation. ***Additional documentation pertaining to the entity's existence and operations may be requested by the company as necessary.***

B. A copy of the entity organizational chart (flowchart) listing any subsidiaries, joint ventures, etc. including a brief description of how they interact and copies of contracts between the entities, may be requested by the company as necessary.

C. A copy of your most recent entity professional liability policy (including all endorsements), may be requested.

D. Answer all questions; if a question is not applicable, state "N/A" NOT APPLICABLE.

E. If space is insufficient to provide your complete answer to any question, please make copies of the page or use the Supplemental Section.

F. Complete Roster of Staffing for all individuals employed by, under contract to or having any type of ownership interest in the entity.

G. Please read and initial the State Statutory Requirement in Section IX. of the application. Applications will not be processed without completion of this statutory requirement.

I. ORGANIZATION INFORMATION

If additional space is needed, please use supplemental form

A1. TYPE OF LEGAL ENTITY (Please put an "X" in the applicable spaces)

- ☐ Professional Corporation - sole shareholder
  - ☐ Shared Limit Coverage with my Medical Protective Individual Limits Policy *(No Employed or Contracted Dentist or Physicians)*
  - ☐ Separate Entity Limits
- ☐ Professional Corporation - multiple shareholders
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Corporation (LLC)
- ☐ General Business Corporation
- ☐ Governmental *(State, Local, or Federal)*
  - ☐ Not-For-Profit Clinic
  - ☐ For-Profit Clinic
- ☐ Other (please explain): ____________

A2. TYPE OF ORGANIZATION (Please put an "X" in the applicable spaces)

- ☐ Private Practice Dental Office
- ☐ Administrative, billing and management entity
- ☐ Dental School
  - ☐ Faculty ☐ Full Time ☐ Part Time
  - ☐ Students ☐ Full Time ☐ Part Time
- ☐ Managed Care Organization/Managed Services Organization
- ☐ Clinic
- ☐ Governmental Clinic
- ☐ Veterans Administration/Military Clinic
- ☐ Prison/Penitentiary
- ☐ Short Term Correctional Facility
- ☐ State Licensed Dental Surgical Center
  - ☐ JCAHO Approved
- ☐ Mobile Dental Practice
- ☐ Nursing Home Based Practice
- ☐ Dental Laboratory
  - ☐ Your Patients Only
  - ☐ For use by other dentists
- ☐ Pharmacy
- ☐ Other (please explain): ____________

B. ENTITY NAMES: (As stated in the articles of incorporation and all formal Entity/Clinic Names. failure to provide complete names may void coverage).

ENTITY NAME

Federal Tax I.D. Number

C. IF THE ABOVE ENTITY DOES BUSINESS UNDER ANY OTHER NAME, PLEASE LIST ALL ADDITIONAL ENTITY/CLINIC NAMES (e.g. DBA, fictitious, etc.):

____

____

D. IS THIS ENTITY ASSOCIATED WITH A CURRENT MEDICAL PROTECTIVE INSURED? ☐ YES ☐ NO

If yes, please provide the Individual, Corporation or Partnership policy and group number if known.

Policy#: ______ Group#: ______ Sub-Group#: ______

E. OFFICE LOCATIONS OF PRACTICE (PLEASE LIST PRINCIPAL LOCATION FIRST)

(Combined Percentage of Practice for all 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

3.

% Of Practice NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE -

COUNTY

F. IN WHICH STATE(S) IS THIS ENTITY AUTHORIZED TO DO BUSINESS?

State of Incorporation: ______________________________

Certificate of Authority: ______________________________

G. PREFERRED MAILING/BILLING ADDRESS: ☐ Office# ______________ (FROM SECTION E) ☐ Other (PLEASE ENTER BELOW)

SUITE NUMBER & STREET

CITY STATE ZIP CODE -

H. PREFERRED METHOD OF CONTACT: ☐ E-MAIL ☐ BUSINESS FAX ☐ BUSINESS PHONE

CONTACT (OR OFFICE MANAGER)

LAST NAME FIRST NAME

TITLE

E-MAIL ADDRESS

BUSINESS FAX - - BUSINESS PHONE - -

II. GENERAL INFORMATION

If additional space is needed, please use supplemental form

If additional space is needed for an explanation(s), attach a separate page and reference the related question number with the answer.

A. DOES THE ENTITY USE A COLLECTION AGENCY THAT HAS THE AUTHORITY TO FILE COLLECTION SUITS WITHOUT YOUR KNOWLEDGE? ☐ YES ☐ NO ☐ N/A

If yes, please explain: ____________________

B. DOES THE ENTITY OWN OR SHARE OWNERSHIP IN A HOSPITAL, NURSING HOME, CLINIC OR OTHER HEALTH CARE FACILITY? ☐ YES ☐ NO

If yes, please explain: ____________________

C. HAS YOUR ORGANIZATION OR ANY OF YOUR EMPLOYEES:

1. Ever been the subject of disciplinary investigative proceedings or a reprimand by a Governmental Licensure Board or administrative agency, hospital or professional association? ☐ YES ☐ NO

If yes, please explain and include dates and individuals involved:

____________________ Individual(s) From: MM - YYYY To: MM - YYYY ____________________ Explanation

2. 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 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 include dates and individuals involved:

____________________ Individual(s) From: MM - YYYY To: MM - YYYY ____________________ Explanation

3. Ever had any professional liability insurance refused, declined, canceled or nonrenewed by the insurance company? ☐ YES ☐ NO

If yes, please explain and include dates and individuals involved:

____________________ Individual(s) From: MM - YYYY To: MM - YYYY ____________________ Explanation

D. DOES THE ENTITY OWN OR OPERATE ANY LABORATORY? ☐ YES ☐ NO

1. Is the laboratory providing services solely for your patients? ☐ YES ☐ NO

If no, please explain: ____________________

E. DOES THE ENTITY MAINTAIN CURRENT CERTIFICATES OF INSURANCE ON FILE FOR ALL DOCTORS AND ALLIED HEALTH CARE PROVIDERS EMPLOYED, CONTRACTED OR PRIVILEGED AT THIS FACILITY? ☐ YES ☐ NO

If no, please explain:

F. WILL THE ENTITY BE PERFORMING ACTIVITIES THAT WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY? ☐ YES ☐ NO

If yes, state practice name, location and carrier name:

____________________ Practice Name ____________________ Location ____________________ Carrier Name

G. HAS THE ENTITY PERFORMED ANY CONTRACT WORK FOR OR ENTERED INTO ANY CONTRACT OR AGREEMENT (WRITTEN OR ORAL) WITH ANY ENTITY/CITY/COUNTY/STATE/FEDERAL AGENCY/CLINIC INCLUDING PROVIDING CARE AT CORRECTIONAL FACILITIES, PRISONS, MENTAL HEALTH FACILITIES, VETERANS ADMINISTRATION, UNIVERSITY, MILITARY, INDIGENT CARE OR CHILDREN'S CLINICS, ETC.? ☐ YES ☐ NO

If yes, please specify and explain: ____________________

H. IS THE ORGANIZATION INVOLVED OR HAS IT HAD ANY 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 ☐ N/A

If yes, please explain: ____________________

I. IF GENERAL ANESTHESIA IS ADMINISTERED OUTSIDE OF A HOSPITAL SETTING:

1. Is scheduled preventative maintenance performed on all biomedical equipment each year by a qualified biomedical technician? ☐ YES ☐ NO

If no, please explain: ____________________

2. If general anesthesia is administered outside of a hospital setting and you provide outpatient surgical services:

a. Is the facility accredited by either ☐ JCAHO ☐ AAAHC ☐ YES ☐ NO

b. Does the entity have a dental services review committee? ☐ YES ☐ NO

c. Does your recovery room provide full time observation by a qualified health care provider? ☐ YES ☐ NO

Please explain all "no" answers for questions I. 2. a, b, or c: ____________________

____

____

II. GENERAL INFORMATION (Continued) *If additional space is needed, please use supplemental form*

J. DOES YOUR ORGANIZATION AND MEMBERS THEREOF, FOR WHICH THIS APPLICATION INCLUDES:

1. Adhere to Americans with Disabilities Act and treat patients with disabilities, including patients with HIV/AIDS? ☐ YES ☐ NO

2. Take precautions against blood-borne diseases in your practice:

a. Including but not limited to wearing masks and surgical gloves? ☐ YES ☐ NO

b. Autoclave/sterilize equipment after each patient? ☐ YES ☐ NO

c. Adhere to OSHA/CDC guidelines? ☐ YES ☐ NO

Please explain all "no" answers for questions J. 1. or I. 2. a, b, or c: ____________________

K. DOES YOUR ORGANIZATION HAVE A WRITTEN DOCUMENT THAT DEFINES THE SERVICES PROVIDED IN YOUR OFFICE? ☐ YES ☐ NO

L. DOES YOUR ORGANIZATION HAVE AN ESTABLISHED PROCESS FOR FOLLOWING-UP ON PATIENT DIAGNOSTIC AND LAB TEST RESULTS? ☐ YES ☐ NO ☐ N/A

If yes, please provide the implementation date: ☐☐ - ☐☐☐☐ (MM - YYYY)

If yes, does the process include:

1. Results reviewed by the doctor and documented? ☐ YES ☐ NO
If no, please explain: ____________________

2. Decision on care documented? ☐ YES ☐ NO
If no, please explain: ____________________

3. Patients notified promptly of test results and noted in file? ☐ YES ☐ NO
If no, please explain: ____________________
If no, are you willing to establish a process going forward? ☐ YES ☐ NO

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

If yes, did your practice complete:

1. A risk/benefit analysis prior to implementing? ☐ YES ☐ NO
If no, please explain: ____________________

2. Appropriate credentialing and training of all staff? ☐ YES ☐ NO
If no, please explain: ____________________

3. A review of existing policies and procedures for necessary updates? ☐ YES ☐ NO
If no, please explain: ____________________

N. DO YOU HAVE A COMPREHENSIVE SYSTEM FOR DOCUMENTING PATIENT CARE? ☐ YES ☐ NO

If yes, does it include:

1. The clinical rationale for decisions? ☐ YES ☐ NO
If no, please explain: ____________________

2. Patient education to help the patient make informed decisions about their health care? ☐ YES ☐ NO
If no, please explain: ____________________

3. Documentation of patient telephone conversations and messages? ☐ YES ☐ NO
If no, please explain: ____________________

O. DO YOU HAVE PROCEDURES THAT SCREEN AND TRACK THE RATIONALE FOR REQUESTING HEALTH CARE RECORDS TO ENSURE THAT ONLY THE PERSON LEGALLY AUTHORIZED TO REQUEST A COPY OF RECORDS, ACTUALLY OBTAINS ACCESS TO THEM? ☐ YES ☐ NO

If no, are you willing to establish a process going forward? ☐ YES ☐ NO

P. DO YOU HAVE A POLICY AND PROCEDURE MANUAL IN YOUR OFFICE? ☐ YES ☐ NO

If yes, please check the topics addressed in your manual:

☐ Human Resources	☐ Office Operations	☐ Medication Management	☐ Other, (please explain): ________
☐ Patient Registration	☐ Patient Care	☐ Appointment Scheduling	________
☐ Confidentiality	☐ Documentation	☐ Billing & Collections	
☐ Health Care Records	☐ Patient Complaints	☐ Disclosure of Adverse Events	
☐ Facility Management	☐ Terminating Patient Relationship	☐ Informed Consent/Refusal	

If no, are you willing to create a manual going forward? ☐ YES ☐ NO

If yes, indicate estimated implementation date: ☐☐ - ☐☐☐☐ (MM - YYYY)

Which topics will be included:

☐ Human Resources	☐ Office Operations	☐ Medication Management	☐ Other, (please explain): ________
☐ Patient Registration	☐ Patient Care	☐ Appointment Scheduling	________
☐ Confidentiality	☐ Documentation	☐ Billing & Collections	
☐ Health Care Records	☐ Patient Complaints	☐ Disclosure of Adverse Events	
☐ Facility Management	☐ Terminating Patient Relationship	☐ Informed Consent/Refusal	

Q. ARE ANY OF THE FOLLOWING TYPES OF PATIENT CARE SERVICES RENDERED WITHIN THE FACILITY?
(If yes, please put an "X", and explain on a separate sheet of paper).

- ☐ Sargenti Root Canal Therapy
- ☐ Services for Obesity/Weight Control
- ☐ Implants
  - ☐ Prosthesis (Abutment Only)
  - ☐ Surgical Anchor
- ☐ Third Molar Extractions
- ☐ TMJ Surgery
- ☐ Surgical Placement of TMJ Implant
- ☐ Pain Management
- ☐ Face Lifts
- ☐ Bleaching/Whitening Agents
- ☐ Permanent Eye/Lipliner/Tattooing
- ☐ Botox Injections
- ☐ Skin Peels
- ☐ Experimental Surgery
- ☐ Research/Experimental Drugs/Product Studies
- ☐ Alternative (Holistic) Dentistry/Medicine
  Please Explain: ____________________
- ☐ Spa Services
  Please Explain: ____________________

R. INDICATE THE PERCENTAGE OF THE PRACTICE DEVOTED TO THE FOLLOWING ACTIVITIES: (Does not have to equal 100%)

___ % Dentures:
- ☐ We Accept Referrals
- ☐ Replacement Dentures
- ☐ Same Day or Economy Dentures
- ☐ Relines

___ % Oral Surgery (extractions, removal of cysts, Invasive Surgical Procedures, etc.)
- ☐ We accept Oral Surgery Referrals

___ % Elective facial cosmetic surgery/procedures (including Rhinoplasty, Face-Lifts, Skin Grafts, Botox, Collagen, Tattooing, 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: ____________________

___ % Other Dental Techniques that will help Medical Protective better understand any special circumstances concerning the practice.
List Procedures: ____________________

S. HAS THE PRACTICE DISCONTINUED ANY PROCEDURES? ☐ YES ☐ NO

Which procedure(s)? ____________________

When ? ___ - ____ (MM YYYY) Why? ____________________

T. PERCENTAGE OF FEES DERIVED FROM MEDICARE/MEDICAID REIMBURSEMENT? ___ %

PERCENTAGE OF FEES DERIVED FROM CAPITATION REIMBURSEMENT? ___ %

U. IS YOUR PRACTICE AFFILIATED WITH A GROUP DENTAL PRACTICE, ADMINISTRATIVE ENTITY OR PRACTICE MANAGEMENT ORGANIZATION? ☐ YES ☐ NO

If yes, please complete questions 1 - 5.

1. Are all offices supervised by the dental practice owner? ☐ YES ☐ NO Number of Locations: ____
   If no, please explain: ____________________
2. Are referral guidelines established by the organization? ☐ YES ☐ NO
3. Please indicate each of the following credentialing standards that are in place for the organization.
   - ☐ Working Interview
   - ☐ Background Check
   - ☐ Verify Training References
   - ☐ Other:
4. Is there a training program in place for new hires including new graduate dentists? ☐ YES ☐ NO
   If yes, please describe: ____________________
   (Please use supplemental page if more space is needed.)
5. If you are submitting a group of insureds, is this one buying decision? ☐ YES ☐ NO
   If no, please explain: ____________________

III. BUSINESS PRACTICES

If additional space is needed, please use supplemental form

Please indicate with an "X" each of the procedures performed within the entity and "X" if informed consent is obtained for each of the procedures checked or referred outside your practice.

Procedure	Do you obtain informed consent?	Check here if these procedures are referred outside of your practice to residency trained licenced specialist.
☐ ***These procedures are not performed***		
☐ Full Mouth Banding Orthodontics	☐ YES ☐ NO	☐
☐ Dental Implants (Anchor portion only)	☐ YES ☐ NO	☐
☐ Partial Impacted Third Molar Extractions (D7210, D7220, D7230)	☐ YES ☐ NO	☐
☐ Fully Impacted Third Molar Extractions (D7240, D7241, D7250)	☐ YES ☐ NO	☐
☐ Conscious Sedation (D09240, D09242)	☐ YES ☐ NO	☐
☐ General Anesthesia Sedation (D09220)	☐ YES ☐ NO	☐
☐ Facial Cosmetic Surgery	☐ YES ☐ NO	☐
☐ Other (Please Explain): ____________	☐ YES ☐ NO	☐

IV. ANESTHESIA INFORMATION

If additional space is needed, please use supplemental form

A. AS DEFINED BELOW, PLEASE "X" IF YOU, A SHAREHOLDER, 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 V.***

☐ ***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. PLEASE INDICATE WHO ADMINISTERS CONSCIOUS SEDATION:

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

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

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

FOR:
☐ Own Patients
☐ Other Than Own Patients

C. PLEASE INDICATE WHO ADMINISTERS GENERAL ANESTHESIA:

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

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

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

FOR:
☐ Own Patients
☐ Other Than Own Patients

D. HOW OFTEN DOES YOUR PRACTICE UPDATE HEALTH HISTORIES?

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

IV. ANESTHESIA INFORMATION (Continued) *If additional space is needed, please use supplemental form*

E. ARE THE OFFICES CERTIFIED FOR GENERAL ANESTHESIA BY A STATE ORGANIZATION? ☐ YES ☐ NO

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

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

G. HAS THE ORGANIZATION CONFIRMED THAT ALL ANESTHESIA PROVIDERS ALLOWED INTO YOUR OFFICE HAVE A MINIMUM TWO YEAR ANESTHESIA RESIDENCY AND PROFESSIONAL LIABILITY LIMITS EQUAL TO OR GREATER THAN YOUR LIMITS?

If no, please explain: ______________________________

H. IF A CRNA IS UTILIZED, ARE THEY SUPERVISED ON SITE BY A DOCTOR WITH A MINIMUM OF TWO YEARS ANESTHESIA RESIDENCY OR GREATER? ☐ YES ☐ NO

If no, please explain: ______________________________

I. IS THE ANESTHESIA PROVIDER CURRENTLY LICENSED IN YOUR STATE? ☐ YES ☐ NO

If no, please explain: ______________________________

J. ARE INDIVIDUALS 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

If no, please explain: ______________________________

K. IS THE FOLLOWING EQUIPMENT UTILIZED? ☐ YES ☐ NO

If yes, please "x" equipment used.

*Verify that the practice will insure that all Anesthesiologists allowed in your practice 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
- ☐ CO2 Monitor
- ☐ Internal/External Temperature Monitor
- ☐ Tracheostomy/Coniotomy Equipment
- ☐ Portable Suction
- ☐ Capnography
- ☐ Auxiliary Lighting
- ☐ Emergency Pharmaceutical Kit
- ☐ Direct Current Defibrillator

If no, please explain: ______________________________

L. DOES THE PRACTICE 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: ***(Please check all that apply)***

☐ One single dose the day of appointment

☐ Multiple doses: ☐ Prior to the scheduled appointment ☐ During the appointment

V. ROSTER OF STAFFING

If additional space is needed, please use supplemental form

PLEASE IDENTIFY ALL OWNERS, EMPLOYED AND CONTRACTED INDIVIDUALS WITHIN YOUR ORGANIZATION AND PROVIDE INFORMATION CONCERNING EACH MEMBER IN EACH CATEGORY LISTED BELOW.

Use the following Key for Individual Status (column 6).

A. Previous Medical Protective insured requesting Medical Protective Coverage
B. Current Medical Protective insured
C. Requesting Medical Protective Coverage
D. Applying for coverage elsewhere or covered elsewhere
E. Other-Including OHCP (Allied Staff) or Office Manager, etc. (requesting to share limits with the Entity)

***** Note Include all applicant(s), all health care providers and non-health care owners.***

If Entity coverage is provided, it will include Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds as defined by a Shared Limit Additional Insured Endorsement.

	1. Last name first, then first and middle initials (i.e. Smith, J. G.)	2. Degree	3. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	4. Percentage of ownership (if shareholder or partner) Enter as a Decimal	5. Specialty (Refer to list on next page)	6. Individual Status- A,B,C, D or E (See Key Above)	7. Medical Protective Policy#
1.				.			
2.				.			
3.				.			
4.				.			
5.				.			
6.				.			
7.				.			
8.				.			
9.				.			
10.				.			
11.				.			
12.				.			
13.				.			
14.				.			
15.				.			

Key: enter specialty per the following: (Please use the number referenced 1-16 in lieu of writing out the specialty).

1. General Dentist
2. Oral Maxillofacial Surgeon
3. Orthodontist
4. Pediatric Dentist
5. Periodontist
6. Prosthodontist
7. Endodontist
8. Dental Anesthesiologist
9. Oral Pathologist
10. Pain Management
11. Dental Assistant
12. Dental Hygienist
13. Office Manager
14. Dental Lab Technician
15. Nurse Anesthetist/CRNA
16. RN/LPN
17. X-Ray Technician
18. Other (Specify job desc. below)*

V. ROSTER OF STAFFING (Continued)

If additional space is needed, please use supplemental form

Please provide a brief job description and explanation for why coverage is not requested for any individuals where Individual Status is ***D*** on Roster or Specialty is #18-Other

Number from Roster	*Job Description*	*Explanation*

VI. LOSS INFORMATION (IMPORTANT, COMPLETE FULLY)

If additional space is needed, please use supplemental form

Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

A. Has your organization or any of your employees/contractors been involved now or in the past, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization? ☐ YES ☐ NO

If yes, how many? ______

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

B. Does your organization or any of your employees/contractors 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 involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization 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 COPIES 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): ______________________________

____

____

____

____

____

____

____

VIII. COVERAGE INFORMATION

If additional space is needed, please use supplemental form

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS FOR THE ENTITY BEGINNING WITH THE MOST RECENT.

1. ______________________ Current Insurer for the Entity
☐ Claims Made ☐ Occurrence
MM - DD - YYYY ***to*** MM - DD - YYYY

2. ______________________ Insurer for the Entity
☐ Claims Made ☐ Occurrence
MM - DD - YYYY ***to*** MM - DD - YYYY

3. ______________________ Insurer for the Entity
☐ Claims Made ☐ Occurrence
MM - DD - YYYY ***to*** MM - DD - YYYY

B. COVERAGE DESIRED

1. ☐ Occurrence
2. ☐ Claims-Made Coverage without Prior Acts Coverage
3. ☐ Claims-Made Coverage with Prior Acts Coverage
4. ☐ Convertible Claims-Made

(A copy of current declaration page showing current retroactive date must be attached for options 3 and 4)

If 1 or 2 are selected from the above and the most recent prior coverage was issued on a Claims Made basis, please select 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 from 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 ENTITY 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-filed***

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

(Requested limits may not be available from this company)

IX. 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

X. 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 entity, affiliation, or working arrangement with any other physician, 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 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 my organization, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

By signing this application on behalf of an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity) I warrant that I am an Officer, Partner, Office Administrator or other Authorized Representative of the entity applying for coverage.

Application must be signed by a President, Chief Executive Officer, or other Officer or Partner of a PC or PA or the Office Administrator or equivalent Authorized Representative.

______________________________ ***Signature***

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

______________________________ ***Print Name/Title***

______________________________ ***E-mail***

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

FOR OFFICE USE ONLY Status: ☐ *Entity* ☐ *Entity Adding to an Existing Group* ☐ *Entity & Individual* ☐ *Groups (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: ______________________

XI. SUPPLEMENTAL FORM

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