



ProNational[®]

INSURANCE COMPANY

A ProAssurance Company

Dental Professional Liability Insurance Application Form

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

1. Current insurance policy declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Articles of Incorporation, if applicable.
5. Loss runs from all prior insurance companies or explanation as to why they are not available.
6. Copy of curriculum vitae.

Note: Submission of a completed application confers no obligation upon the Company to bind coverage.

ProNational Insurance Company
P.O. Box 150
Okemos, Michigan 48805-0150
517/349-6500 800/292-1036

3. Coverage Selection

Requested Effective Date: _____
 Month Day Year

A. Primary Coverage Limits: Indicate your desired level of primary coverage by placing an “X” in the appropriate box.

Illinois	Michigan	Pennsylvania	All Other States
<input type="checkbox"/> \$250,000/\$750,000	<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$1,000,000/\$3,000,000
<input type="checkbox"/> \$500,000/\$1,500,000	<input type="checkbox"/> \$200,000/\$600,000	<input type="checkbox"/> \$200,000/\$600,000	
<input type="checkbox"/> \$1,000,000/\$3,000,000	<input type="checkbox"/> \$300,000/\$900,000	<input type="checkbox"/> \$500,000/\$1,500,000	
	<input type="checkbox"/> \$500,000/\$1,000,000	<input type="checkbox"/> \$1,000,000/\$3,000,000	
	<input type="checkbox"/> \$1,000,000/\$3,000,000		

B. Excess Coverage Limits: Indicate your desired level of excess coverage by placing an “X” in the appropriate box.
 Excess coverage limits are not required but are recommended.

Note: Excess Coverage is available on a limited basis in Wisconsin

- \$1 million additional
 \$2 million additional

Coverage will become effective only after the completion of all underwriting functions and acceptance by the Company.

4. Licensing Information – List all states in which you are or have been licensed to practice Dentistry/Oral Surgery.

State	License Number	% of Practice	Which County?	Member of State Dental Association?	
_____				Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____				Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____				Yes <input type="checkbox"/>	No <input type="checkbox"/>

5. Professional Liability Insurance History

Name of Company (Current)	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence

A. Have you ever applied to Mutual Assurance, Medical Assurance, ProNational or Red Mountain Casualty for insurance before?.....Yes No

B. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage?.....Yes No
If yes, requested retroactive date: _____

Important: If you are not applying for prior acts coverage and are not purchasing a reporting endorsement from your current carrier, please explain why on a separate sheet.

C. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions?Yes No

Important: If you answered yes to question 5C, please submit a **complete explanation** on a separate sheet of paper.

Important information regarding questions 5D and 5E (including sub-questions):

1. The Word "claim" as used in Questions 5D and 5E following refers to:
 - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
 - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer yes to questions 5D through 5E (including sub-questions), please complete the attached Supplementary Claims Information Form (page 19).

D. Have you ever been involved in a malpractice claim or suit, either directly or indirectly?.....Yes No
If yes, indicate how many: _____

E. Other than the claims/suits indicated in 5D above, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit?.....Yes No

i. A request for records from a patient and/or attorney related to an adverse outcome?...Yes No

ii. A letter from an attorney regarding your dental treatment of a patient?Yes No

iii. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability or the need for follow-up surgery?Yes No

iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis?.....Yes No

v. Any other circumstances that might reasonably lead to a claim or suit?.....Yes No

vi. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? N/A* Yes No

a. If yes, how many? _____ Please attach documentation of all such reports.

b. If no, please explain on pages a separate sheet.

* For purposes of this question, "N/A" means that you are aware of no circumstances that might reasonably lead to a claim or suit.

Important: If you answer yes to questions 5F through 5O, please provide details on a separate sheet.

- F. Has your license to practice dentistry or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? Yes No
- G. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? Yes No
- H. Have you ever failed any licensing or Board Certification examinations? Yes No
If yes, how many times? _____
- I. Have you ever been refused hospital privileges? Yes No
- J. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Dental Examiners, or other dental review committee? Yes No
- K. Have you ever had a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Dental Examiners, or other dental review committee? Yes No
- L. Have you ever been convicted of or pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? Yes No
- M. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? Yes No
- N. Have you ever been accused of sexual misconduct of any kind? Yes No
- O. Do you have any physical handicap or any chronic illness? Yes No

6. Rating Information

- A. Do you perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as the medium for rendering dental services, dental opinions or dental advice (teledentistry or internet dentistry)? Yes No
 - i. If yes, please indicate all states in which the patients being treated reside:

 - ii. What percentage of your total practice does teledentistry constitute? _____ %
- B. Do you now or have you ever provided services to any state, local or federal correctional facility, jail or prison? Yes No

C. What percentage of your practice is in the following areas? (Please account for 100% of your practice.)

- i. Endodontics _____ %
a. Do you use the Sargenti Method? Yes No
If yes, do you obtain a signed consent form from each patient?..... Yes No

- ii. Orthodontics _____ % Comprehensive _____ % Limited/Interceptive _____ %

a. What pre-diagnostic procedures do you utilize?

- Informed consent form
- Cephalometric x-rays
- Pantographic/panoramic x-rays
- Study casts and photographs
- Full mouth surveys
- Other _____

- b. Do you perform comprehensive orthodontic services? Yes No
If yes, please complete the following:

1) Describe types of services performed.

2) Describe courses taken, indicating institution and hours of clinical and/or didactic instruction.

- iii. Periodontics _____ %

- a. Does care include surgical treatment? Yes No
If yes, list pertinent procedures.

- iv. Pedodontics _____ %

- v. Prosthodontics _____ %

- vi. Oral and Maxillofacial Surgery _____ %

a. Do you perform either of the following?

Surgical removal of impacted teeth..... Yes No

Maxillary and/or mandibular osteotomies..... Yes No

- b. Do you perform any other oral/maxillofacial surgical procedures? Yes No
If yes, please complete the following:

i) List pertinent procedures.

ii) List hospitals, clinics or other facilities where you perform these procedures.

c. Do you act as an assistant surgeon for any oral/maxillofacial surgical procedures? Yes No

i) List pertinent procedures.

ii) List hospitals, clinics or other facilities where you perform these procedures.

vii. General Dentistry (incl. simple extractions, but not procedures listed above) _____ %

viii. TMJD Services _____ %

a. Do you limit your practice to non-surgical TMJD treatment? Yes No

b. Do you provide occlusal adjustment therapy? Yes No

c. Do you provide splint therapy? Yes No

d. Do you ever provide orthodontic treatment to TMJD? Yes No

e. Have you obtained additional training in TMJD since graduation from dental school? Yes No

If yes, describe course taken indicating institution and hours of clinical and/or didactic instruction.

ix. Do you perform cosmetic dentistry? Yes No

If yes, list types of procedures performed. _____

x. Do you place implants? Yes No

If yes, please complete the following:

a. Types of implants _____

b. Number of cases per year _____

c. Special training received (school, hours) _____

xi. If you do not place implants, are you providing prosthetic restorations on implants only? Yes No

xii. Do you perform any diagnostic or therapeutic procedures which have been introduced to you and/or the dental profession within the past 18 months? Yes No

If yes, please explain. _____

xiii. Do you perform acupuncture? Yes No

If yes, submit certificates of completion from courses taken, indicating the number of hours of clinical and/or didactic instruction.

xiv. Do you practice homeopathy? Yes No

If yes, please complete the following:

a. What percentage of your practice is devoted to homeopathy? _____ %

b. What type of formal homeopathic education (schools, courses) have you had?

c. What type of homeopathic clinical training (preceptorship/experience) have you had?

d. Do you participate in any study groups pertaining to homeopathy?Yes No

If applicant is approved for coverage it will be his/her responsibility to notify the Company of any changes in practice specialty, including but not limited to practice location, procedures, affiliation, etc. Failure to notify the Company of such changes could require retroactive upward premium adjustment and in the event of a claim could lead to a denial of coverage.

7. Anesthesia Information

A. Note: This question inquires as to your use of anesthetics and analgesia. Make certain you read and answer all parts very carefully. If you administer general anesthesia in any form, please also complete the general anesthesia questionnaire following this question. If you do not use general anesthesia skip the general anesthesia questionnaire.

i. Do you limit your practice to local anesthesia and/or oral medication?Yes No

ii. Do you treat patients who have been subjected to Nitrous Oxide or who have been administered any other form of inhalation sedation?.....Yes No

iii. Do you treat patients who have been administered any form of intravenous sedation or intramuscular sedation?Yes No

iv. Do you treat patients who have been rendered unconscious by any form of general anesthesia?.....Yes No
If yes, is this done in-office, hospital, or outpatient clinic? _____

v. Please briefly describe below your use of anesthetics, both local and general. Also describe your use of any type of analgesia.

General Anesthesia Questionnaire

- A. How many times per week do you use general anesthesia in your office?
 Over 20 10 to 20 5 to 10 Less than 5
- B. How long have you used general anesthesia on a daily basis?
 Over 10 years 3 to 10 years Less than 3 years Not used daily
- C. What type(s) of anesthesia do you use?
 Local Inhalation Intravenous Combination
- D. What types of oral surgery do you perform?
 Minor (Alveolar) Major (other procedures)
- E. Where do you perform procedures?
 Office Hospital Office and Hospital
- F. How many of the following employees does your operating team include?
 # _____ Office trained dental assistants # _____ Nurse anesthetists # _____ Other dentist or MDs
 # _____ Surgical assistants # _____ Registered nurses # _____ Licensed practical nurses
 # _____ Other _____
- G. Are you equipped and trained to use positive pressure endotracheal respiratory assistance? Yes No
- H. Do you intubate patients for airway maintenance under general anesthesia? Yes No
 If yes, how often per month? _____
- I. How many months of University or Hospital training in general anesthesia/analgesia do you have?
 Over 12 months 6 to 12 months 3 to 6 months Less than 3 months
- J. Have you participated in an office Self Evaluation Program of your peers in the past 5 years? Yes No
- K. Please indicate your certification information.
 ACLS Certified BCLS Certified Not Certified
- L. Please list the names of others in your office that are certified and specify ACLS or BCLS.
- | Full Name of Employee | Type of Certification |
|-----------------------|-----------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
- M. Please indicate the types of equipment available and properly maintained in your office:
- | | |
|---|---|
| <input type="checkbox"/> ECG | <input type="checkbox"/> Intubation Equipment |
| <input type="checkbox"/> Anesthesia Machine | <input type="checkbox"/> Temperature Monitor |
| <input type="checkbox"/> Oxygen Source | <input type="checkbox"/> IV Set Up |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> BP Monitor |
| <input type="checkbox"/> AMBU Bag | <input type="checkbox"/> Resuscitative & Emergency Drugs (Crash Cart) |
| <input type="checkbox"/> Suction Apparatus | <input type="checkbox"/> None |

8. Managed Care Contract Information

Name of Managed Care Organization	Approximate % of Total Patients	Capitated	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>

9. Educational Information

Name of Dental School(s) Attended	Location of Dental School(s) Attended	Degree	Date Graduated

If you are a foreign dental school graduate, have you ever failed the examination Education Council for Foreign Dental School Graduates?Yes No
 If yes, how many times? _____

Post-graduate Training					
Hospital Data		Specialty and/or Department	Dates (Month/Year)		Completed
Name	Location		Start	End	
					Yes <input type="checkbox"/> *No <input type="checkbox"/>
					Yes <input type="checkbox"/> *No <input type="checkbox"/>
					Yes <input type="checkbox"/> *No <input type="checkbox"/>
					Yes <input type="checkbox"/> *No <input type="checkbox"/>

* If no, explain fully on a separate sheet.

Other Dental Education (Category I Continuing Dental Education Programs) Completed in the Past Three Years		
Courses Completed	CDE Credits Received	Date(s) Attended Month/Year

10. Practice History

Please list locations where you have practiced since training.

Location	Dates (Month/Year)*	
	Start	End
* Provide brief description of each practice situation, including clinical responsibilities, and explain any gaps in practice on pages 17-18 and/or a separate sheet.		

11. Hospital Affiliations and Privileges

A. Please indicate hospitals where you have, or have had active privileges.

Hospital Data			Dates (Month/Year)		Percentage of Your Patients Admitted to This Facility
Name	Location (City & State)	Department	Start	End	

B. Please list hospitals where you have applied for privileges, but have not yet been accepted.

Hospital Data			Dates (Month/Year)		Percentage of Your Patients to be Admitted to This Facility
Name	Location (City/State)	Department	Start	End	

C. Please list hospitals where you have been denied privileges. **Explain any denial of privileges on a separate sheet.**

Hospital Data			Date Denied
Name	Location (City & State)	Department	(Month/Year)

12. Practice Organization

A. Coverage is desired for: (check all that apply)

- Solo Entity: Name _____ Shared Limits Only*
 Corp. Tax ID # _____ Date of Incorporation _____
- Member of a partnership or multi-shareholder corporation:
 Partnership/Group Name _____ Separate Limits
 Corp. Tax ID # _____ Date of Incorporation _____ Shared Limits*
- Other (i.e., implied partnership, corporation, etc.):
 Entity Name _____ Separate Limits
 Corp. Tax ID # _____ Date of Incorporation _____ Shared Limits*

Please include Articles of Incorporation, accompanied by a list of principals, and a copy of your business letterhead.

* Shared limits are permitted on a very limited basis in Wisconsin.

B. Give the full names of all other dentists affiliated with any organization(s) named in Question 12A. **All affiliated dentists must complete a separate application if organization coverage is to be provided. Use additional sheets if needed.**

Name	Current Dental Professional Liability Insurance Co.

13. Information on Allied Health Care Professionals

The following is a list of “allied health care professionals” for which a separate charge may be required: CRNA, Nurse Practitioner, Surgical Assistant and Anesthesia Assistant.

A. List all such allied health care professionals who provide services in your office as employees:

Name	DOB	SSN	Specialty	Check Desired Limits
				<input type="checkbox"/> Shared* <input type="checkbox"/> Separate
				<input type="checkbox"/> Shared* <input type="checkbox"/> Separate
				<input type="checkbox"/> Shared* <input type="checkbox"/> Separate
				<input type="checkbox"/> Shared* <input type="checkbox"/> Separate
				<input type="checkbox"/> Shared* <input type="checkbox"/> Separate

* Shared limits are not permitted in Pennsylvania and on a very limited basis in Wisconsin.

B. Do you or any member of your group currently supervise an “allied health care professional” (as defined above) who is not in your employ? Yes No
Do you plan to do so in the future? Yes No

C. Indicate the number of the following types of other individuals who provide services in your office as employees:

Number	Position	Number	Position
	Dental Assistant		Dental Hygienist
	Nurse		Laboratory Technician
			Other

14. Additional Data

A. Do any of your employees (not including Dentist/Oral Surgeon) practice at a location geographically separate from yours? Yes No
If yes, please explain on a separate sheet.

B. Do you, or does any partnership or corporation of which you are a member or shareholder, own or operate a surgicenter, dental laboratory or other dental enterprise other than a dental office practice? Yes No

C. Do you perform dental or surgical procedures at a surgicenter, office-based surgical suite or similar facility? Yes No
If yes, please explain on a separate sheet.

IMPORTANT! YOU MUST READ CAREFULLY

GENERAL FRAUD WARNING: 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.

NEW JERSEY FRAUD WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PENNSYLVANIA FRAUD WARNING: 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.

WISCONSIN EXCEPTION: If the company agrees to be bound under the terms of this application, your policy will be cancelled if you hide any important information from us, or attempt to defraud or lie to us about any matter contained in this application.

Specific Consent

to Conditions of Consideration of the Application for Insurance

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

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

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and not an insurance binder.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed dentist/oral surgeon who makes application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

Applicant's Signature

Date

Important: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following page of this Application is an *Authorization To Release Information* form which requires your signature. Please read carefully.

Authorization to Release Information

The undersigned applicant for insurance by ProNational Insurance Company (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Dental Examiners for any state in which he has practiced, or resided, and any and all dentists/oral surgeons or any other third party having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

Date: _____

Additional Comments

Dentists' & Oral Surgeons' Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____
2. Date reported to insurance company: _____
3. Name of insurance company: _____
4. Date of incident and your treatment: _____
5. Allegations: _____

6. What is the present condition of the patient? _____

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

8. Status of claim (check applicable answer):

- Suit threatened, no action taken
- Suit filed but dropped by claimant
- Summary judgment in your favor
- Suit settled out of court
 - a. Date claim paid: _____
 - b. Amount paid: \$ _____
 - c. Did you want to settle this claim? Yes No

Court outcome in your favor:

- Jury verdict
- Directed verdict

Court outcome in favor of plaintiff:

- Jury verdict
- Directed verdict

Amt. of Loss Payment:
\$ _____

Awaiting mediation

Awaiting court action

Reserve Amount:
\$ _____

9. Name and address of the attorney assigned to your case: _____

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

Signature: _____ Date: _____

Name (Printed): _____