The Professional Protector Plan®
Claims-Made
Professional Liability Insurance For Dentists

THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS, AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant in ink.
3. A copy of your letterhead must be included. Also, please include a copy of all of your "Yellow Pages" advertising, if any.

I agree that any coverage issued will be contingent upon the truth of the following information:

☐ New Policy Requested Effective Date ____/____/_____ ☐ Rewrite of Policy Number _____

☐ Renewal of Policy Number: _____ ☐ Web Address: _____

PLEASE TELL US ABOUT YOURSELF

1. Full Name: _____ ☐ DDS ☐ DMD ☐ MD ☐ BDS

2. Mailing Address: _____

City/ State / Zip _____

3. Telephone Number: (_____)_____ 4. Fax Number: (_____)_____ 5. E-mail Address: _____

6. Dental School Attended: _____ 7. Month/Year of Graduation: _____

8. Are you entering practice for the first time? ☐ Yes ☐ No If "Yes", did you complete a residency? ☐ Yes ☐ No

Specialty: _____ Month/year of Completion: _____

9. Date of Birth: _____ 10. Years in Practice: _____

11. Are you currently licensed to practice dentistry?..... ☐ Yes ☐ No

State(s):_____ License #(s):_____

Policy Request Information – Professional Liability

12. Limits Requested:
☐ $ 1,000,000 / $ 3,000,000 ☐ $ 2,000,000 / $ 3,000,000 ☐ $ 2,000,000 / $ 4,000,000 ☐ $ 2,000,000 / $ 6,000,000
☐ $ 3,000,000 / $ 3,000,000 ☐ $ 3,000,000 / $ 6,000,000 ☐ $ 4,000,000 / $ 4,000,000 ☐ $ 5,000,000 / $ 5,000,000
☐ $ 5,000,000 / $ 8,000,000 ☐ Other: _____ (STATE EXCEPTIONS MAY APPLY)

PLEASE TELL US ABOUT YOUR PRACTICE

13. Under which business structure do you practice?

☐ Sole Proprietor ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Incorporated ☐ Partnership

☐ Employee Dentist Name of Employer/Facility: _____

☐ Independent Contractor Name of Employer/Facility: _____

If you own your practice, please complete the following:

A. Name of your legal entity (if any): _____

B. Do you desire shared or separate limits of liability to apply to your legal entity?

☐ Shared (limits are shared with you at no cost) ☐ Separate (entity has its own set of limits and an additional charge applies)

C. Excluding yourself, name all officers or partners of your legal entity: _____
(Attach a separate sheet if necessary)

_____

_____

PLEASE TELL US ABOUT YOUR PRACTICE – Continued

D. Please provide the number of the following who work for you:

☐ Employee dentists (other than yourself and/or partners/corporate officers) * _____

☐ Independent contractor dentists * _____

☐ Other dentists sharing facilities with you who are not covered under this policy) * _____

* NOTE: For any of the ABOVE 3 selections, be sure to attach a separate application or proof of professional liability coverage for each

☐ All other employees (hygienists, assistants, technicians, clerical, etc.) _____

14. Practice Addresses and Percentage of Practice at Each Address (Total of Percentages Must Equal 100%):
Primary

a) _____
Street City County State Zip Code %

b) _____
Street City County State Zip Code %

c) _____
Street City County State Zip Code %

15. How many hours per week do you practice (include lab work, patient visitation and consultation)? _____
If 20 hours or less, please complete a Part-time Supplement

PLEASE TELL US ABOUT YOUR SPECIALTY

16. Indicate your Practice Specialty (please check all that apply)

☐ General Dentistry
☐ Endodontics
☐ Oral/Maxillofacial Surgery
☐ Oral Pathology
☐ Anesthesiology (Dental)-General Anesthesia
☐ Dental Radiologist
☐ Oral Radiology
☐ Orthodontics
☐ Pediatric Dentistry
☐ Anesthesiology (Dental)-Conscious Sedation
☐ Periodontics
☐ Prosthodontics
☐ Public Health
☐ Full-time Faculty-Non-Intramural

PLEASE TELL US ABOUT THE PROCEDURES PERFORMED IN YOUR PRACTICE

17. Which of the following procedures are performed by you or by someone in your practice:

☐ Sleep Apnea Therapy If "Yes", please indicate the following:
☐ I treat only after referral from physician ☐ I treat without physician referral ☐ I fabricate snore guard

☐ "Sargenti," paste fill or formaldehyde based endodontic techniques excluding formocresol primary tooth pulpotomies

☐ Cosmetic dermal procedures (including but not limited to Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.)
If "Yes", please provide an explanation on a separate sheet of paper.

☐ Irreversible TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)

☐ Implant Surgery ☐ Extraction of Impacted teeth ☐ Implant Restoration ☐ Molar Endodontics on Permanent Teeth

☐ None of the above

PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA

18. Anxiety Reduction is defined as "the use of nitrous oxide/oxygen and/or oral premedication used in an accepted therapeutic dose to reduce anxiety."

Conscious sedation is defined as: "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."

General Anesthesia and Deep Sedation are defined as: "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 purposely to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof."

A. Are you treating patients who are under general anesthesia / deep sedation in your office?..... ☐ Yes ☐ No
If "Yes", who administers the anesthesia? ☐ You ☐ Another Dentist, Anesthesiologist or CRNA

PLEASE TELL US ABOUT YOUR DENTAL LABORATORY / DENTAL IMAGING SERVICES

19. Do you operate dental laboratory? ..... ☐ Yes ☐ No
If "yes" do you accept referrals for other than your patients? ..... ☐ Yes ☐ No
20. Do you provide radiology services for other than your patients or on a referral basis? ..... ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR PARTICIPATION

21. Are you a member of your state dental association or society? ☐ Yes ☐ No

22. Have you taken one of the following risk management seminars in the last 3 years? ☐ Yes ☐ No

☐ CNA (Evidence not required if you are a CNA insured) ☐ AAOM ☐ AAO ☐ NYSDA / DSSNY ☐ Henry Spenadel

Date of Attendance ____ /____/_____ If "Yes", provide evidence of attendance

PLEASE TELL US ABOUT YOUR LICENSE AND CLAIMS HISTORY

23. A. Have you had a change in the status of your hospital privileges? ☐ Yes ☐ No
If "Yes", provide details on a separate sheet of paper.

B. Has any governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions? ☐ Yes ☐ No
If "Yes", provide a copy of the board transcript or other documentation, including resolution.

C. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency? ☐ Yes ☐ No
If "Yes", provide a copy of the board transcript or other documentation, including resolution.

D. Have you been convicted of any criminal charges? ☐ Yes ☐ No
If "Yes", provide details from investigating agency.

E. Have you ever been or are currently being treated for alcoholism, drug addiction, mental illness or physical impairment? ☐ Yes ☐ No
If "Yes", provide a letter from treating physician with complete details.

F. Are you now, or have you ever, practiced without professional liability insurance? ☐ Yes ☐ No
If "Yes", provide details on a separate sheet of paper.

G. Have you ever had any professional liability insurance refused, cancelled or non-renewed? ☐ Yes ☐ No
If "Yes", provide details on a separate sheet of paper. THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS

H. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
If "Yes", please complete Supplemental Claim form.

I. Are you currently aware of any situation that could lead to a malpractice suit against you? ☐ Yes ☐ No
If "Yes", please complete Supplemental Claim form.

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

24. List prior insurance carrier(s) for the past three (3) years. If none, state "None."

Insurance Carrier	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability

25. Are you applying for prior acts coverage from CNA? ☐ Yes ☐ No
If "Yes", please attach a copy of your last declaration page (face sheet).

26. Prior Acts date (Retroactive date) used by your previous carrier_____

27. Was an extended reporting endorsement (tail) purchased form your previous carrier? ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR GENERAL LIABILITY NEEDS

28. Do you desire General Liability Coverage? ☐ Yes ☐ No (GL Limits are equal to your Professional Liability Limits but state exceptions may apply)
If "No" General Liability is requested, please continue to the next page.

29. Do you desire Shared or Separate Limits of liability to apply to each location:
☐ Shared (Limits are Shared with each location at no additional cost) ☐ Separate (each location has its own set of limits and an additional charge applies)

30. Have you had any general liability losses in the past three (3) years? ☐ Yes ☐ No

If "Yes", provide date(s) of loss and detail(s). _____

31. Do you desire ERISA Fiduciary Liability Coverage / Employee Benefits Liability? ☐ Yes ☐ No
Coverage is recommended if you sponsor any Employee Benefit Plan. This is NOT the bond for your pension plan. Coverage is written on a Claims-made basis.
If "Yes", check the desired Limits of Liability: ☐ $ 100,000 ☐ $ 250,000 ☐ $ 500,000 ☐ $ 750,000 ☐ $ 1,000,000

32. Would you like to increase the standard $ 500,000 Fire / Water / Legal Liability Limits? ☐ Yes ☐ No
If "Yes", check the desired Limits of Liability: ☐ $ 750,000 ☐ $ 1,000,000

33. If your equipment lease or rental requires you to name the equipment lessor as an additional insured, please provide the name and address of the lessor as it appears on the lease or rental agreement. _____

34. If your building lease requires the building owner to be included as an additional insured for the portion of the premises leased to you, please list the Lessor's name and address as it appears on your lease: _____

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

I understand that my Professional Liability Coverage will be written on a "Claims-Made form" and acknowledge that this coverage will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" coverage will not provide insurance coverage for claims which occurred prior to the "Prior Acts Date" of my policy.

I understand that, should my "Claims-Made" policy with this insurance carrier ever be cancelled or non-renewed, or I decide to terminate it for any other reasons, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy, but were not reported to the insurance company before the date of the policy termination, I will be able to purchase additional insurance coverage.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (For District of Columbia residents only: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.) (For Florida residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) (For Louisiana residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) (For Maine residents only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.) (For New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Oklahoma residents Only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) (For Pennsylvania residents only: 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.) (For Puerto Rico residents only: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousands dollars ($5,000) nor more than ten thousands dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.) (For Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) (For Washington residents only: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.)

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

_____

Signature in full: Date

_____

Agent's Signature Date

REMINDER:

Please attach a sample of your letterhead and a copy of all of your dental practice "Yellow Pages" advertising, if any, to this application.

RETURN TO:

State Administrator Name:

_____

Address:

_____

City: State: Zip Code:

_____

Phone #: (_____)_____

Agent's License Number: _____