The Professional Protector Plan
Claims-Made Renewal Application

PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

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. All questions must be answered. Please do not leave any blanks. If a question is not applicable, please write N/A.
2. Please indicate any desired changes in the appropriate area.
3. Application must be signed and dated by applicant in ink.

Renewal Date: _____ Policy Number: _____

Name_____ Phone: _____

Address _____ Fax: _____

City, State, ZIP Code _____ Email: _____

1. Professional liability limits of liability (claims-made coverage)

☐ $ 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)

TELL US ABOUT YOUR PRACTICE

2. 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: _____

3. 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)

_____

_____

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.) _____

4. 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 %

5. 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 THE PROCEDURES PERFORMED IN YOUR PRACTICE

6. 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

7. 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

8. Do you operate a dental laboratory? ..... ☐ Yes ☐ No
If "Yes" do you accept referrals for other than your patients? ..... ☐ Yes ☐ No

9. Do you provide radiology services for other than your patients or on a referral basis? ..... ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR PARTICIPATION / LICENSE / CLAIM HISTORY

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

11. Have you taken one of the following risk management seminars since your last renewal? ..... ☐ 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

12. During the previous 12 months, have any of the following occurred which have NOT previously been reported to the insurance company?

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.

PLEASE TELL US ABOUT YOUR PARTICIPATION / LICENSE / CLAIM HISTORY - Continued

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.

PLEASE TELL US ABOUT YOUR GENERAL LIABILITY NEEDS

13. Do you desire General Liability Coverage? ☐ Yes ☐ No (GL Limits are equal to your Professional Liability Limits but state exceptions may apply)

14. 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)

15. 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). _____

16. Do you want 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.
Check the desired Limits of Liability: ☐ $ 100,000 ☐ $ 250,000 ☐ $ 500,000 ☐ $ 750,000 ☐ $ 1,000,000

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

18. 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. _____

19. 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, make 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 Date

Agent's Signature Date

RETURN TO:

_____
_____
_____
_____

Practice Property Renewal Supplement

Renewal Effective Date: _____/_____/_____ Name: _____

Policy Number: _____ Practice Address: _____

_____

BUILDING INFORMATION

1. If the building is over 25 years – what year was it last updated? _____

Year roof updated?	Electric Meets Building Code?	Plumbing is maintained to prevent exposure to leaking or frozen pipes?	Building was designed for a different occupancy and has been modified?
	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES If yes, what was building designed for:_____ _____ ☐ NO

2. Name and address of loss payee or lessor on contents (office and dental equipment), if any:

A. _____
Name Street City State ZIP

B. _____
Name Street City State ZIP

3. PROPERTY COVERAGE

Coverage (Replacement Cost)	Standard Limit Provided	Current Coverage Limit	New Limit Desired (if applicable)
A. Practice Contents			
Accounts Receivable, Valuable Papers including x-rays and charts	$25,000		
Dental Practice Blanket Limit Total			
B. Signs not attached to building	$10,000		
C. Contents Inflation guard (May select quarterly increases up to 5% Contact your agent)			
D. Business Interruption Insurance [Valued Practice Income (VPI)] Minimum $300 per day/32.5 days Profit and Loss Statement may be required	Optional	Daily Limit $ _____ # of Days _____ gross annual income/production $_____ average number of days per week the practice is open:_____	
E. Employee Dishonesty			
1. money/securities	$25,000		
2. welfare and pension plans (ERISA Bond)	$25,000		
F. Rents (annual rental income)			
G. Dentist's electronic equipment (including electronic data processing equipment) Do you use surge protector devices?	$50,000 ☐Yes ☐No		
H. Equipment Breakdown coverage ☐ Dental Equipment Only ☐ Dental Equipment and HVAC equipment Do you own the building?.....	☐Yes ☐No ☐Yes ☐No		

Value of Building?.....	$ _____		
I. Fine arts (attach appraisals, if additional coverage is desired)	$25,000 subject to maximum of $1,000 per item		
J. Back up of Sewer and Drain	$25,000		
K. Property deductible – deductibles available are: $250, $ 500, $ 1,000, $ 2,500, $ 5,000, and $ 10,000 STATE EXCEPTIONS MAY APPLY			

4. Building Coverage (If building coverage is not desired, please disregard questions 5 –8.)

Coverage (Replacement Cost)	Standard Limit Provided	Current Coverage Limit	New Limit Desired (if applicable)
Building (current cost to replace)			
a. additional buildings on premises (garage, storage building, etc.)			
b. inflation guard – Contact your agent (May select quarterly increases up to 5%)			
c. Ordinance or Law (Building)	$100,000		

5. Legal Name of building owner: _____

6. Has there been any changes in tenants or vacancy?..... ☐ Yes ☐ No

A . Please indicate tenants by type of business and/or operations conducted and square footage for each. If any vacancy, please indicate % of vacancy

_____ Sq. Feet _____

_____ _____ Sq. Feet _____

B. % of Vacancy

_____ Sq. Feet _____

_____ Sq. Feet _____

7. Name and address of mortgagee (if any):

A. _____
Name Street City State ZIP

B. _____
Name Street City State ZIP

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.

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