The Professional Protector Plan®

Dental Associations, Dental Societies and Dental Testing Boards Supplement

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.

I. GENERAL INFORMATION:

Name of Applicant / Insured (legal name): _____

Corporate Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Mailing Address (if different): _____

Name and Title of Contact Person: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

E-Mail Address: _____ Website: _____

A. Applicant/ Insured is: (check appropriate boxes)

☐ Dental Association ☐ Dental Society

☐ Dental Testing Board ☐ Other: Describe: _____

B. Description of services provided: _____

C. How many years has the applicant/ insured been in operation? _____

II. DENTAL ASSOCIATIONS / SOCIETIES

A. Please provide the names and descriptions of all component societies that should be covered under the policy. If more space is required, provide by attachment.

	Name of Component Society	Description	Date Acquired	Retroactive Date
1				
2				
3				
4				

B. Please provide the names of all annual conventions, dates and locations that should be covered under the policy. If more space is required, provide by attachment.

	Name	Date	Location
1			
2			
3			
4			

III. DENTAL TESTING BOARDS

A. Please provide the names of all examiners*, examination sites and dates that should be covered under the policy. If more space is required, provide by attachment. (Limits of liability will be shared with the Dental Testing Board.)

Note: * Certificates of Insurance are required for those examiners with their own individual coverage and are not covered under this policy.

	Name of Examiner	Date	Location
1			
2			
3			
4			

IV. CONTRACTUAL AGREEMENTS / ADDITIONAL INSUREDS: (If more space is required, please provide by attachment.)

A. Does the applicant/ insured have other business entities that should be added to this policy as an additional insured? ☐ Yes ☐ No
If the response is yes, please provide the names of other business entities, description of services provided and the relationship to the named insured.

	Name of Additional Insured	Description of Services Provided	Relationship to the Named Insured
1			
2			
3			
4			

B. Does the applicant/ insured have written agreements with third parties which include the following:
1. A requirement that the other party supply the applicant with a current copy of a certificate of insurance?. ☐ Yes ☐ No
2. A requirement that that the applicant / insured add the third party as an additional insured? ☐ Yes ☐ No

	Name of Additional Insured	Address of Additional Insured	Description of Services (Leased Equipment, Leased Premises, etc.)
1			
2			
3			
4			

C. Does applicant sponsor any sporting or special events? ☐ Yes ☐ No
If yes, please provide the name of any the event, description, (specialty meeting, public health fair, education event, etc.) dates and locations. (An additional charge is applicable).

	Name of Special Event	Description	Date	Location
1				
2				
3				
4				

D. Does the applicant provide alcoholic beverages at any of these events? ☐ Yes ☐ No

If yes, please explain? _____

Do not complete Sections V., VI., and VII. If you are a current PPP insured

V. PREVIOUS PROFESSIONAL LIABILITY COVERAGE:

Provide complete insurance history for past 5 (five) years beginning with your current insurance carrier. If there is an uninsured period, please write "uninsured". Please be sure to explain any gaps in your coverage.

	Current Year	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year
Insurance Company					
Limits of Liability					
Coverage Form	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made
Retroactive Date					
Policy Period					
Premium					

VI. PREVIOUS GENERAL LIABILITY COVERAGE:

Provide complete insurance history for past 5 (five) years beginning with your current insurance carrier. If there is an uninsured period, please write "uninsured". Please be sure to explain any gaps in your coverage.

	Current Year	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year
Insurance Company					
Limits of Liability					
Coverage Form	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made
Retroactive Date					
Policy Period					
Premium					

VII. LITIGATION/CLAIMS HISTORY SANCTIONS/FINES

If the response was yes to any question below additional information must be provided on the applicant's letterhead. Please submit actual loss runs from the previous carriers for the past five years.

A. Has the applicant had any Professional, General Liability, Employee Benefits or Umbrella claims or suits brought against them in the past 5 years? ☐ Yes ☐ No

B. Is the applicant aware of any incident (including requests for dental records), circumstance or occurrence which may result in a claim and which has not been reported to another carrier? ☐ Yes ☐ No

C. Has any insurance company declined, canceled, or refused to renew or accept any of the applicant's liability insurance? **(THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS)** ☐ Yes ☐ No

D. Has any federal or state civil or criminal investigation or action been initiated or filed that directly or indirectly involve the applicant's organization? ☐ Yes ☐ No

E. Has the organization or any of its officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by federal or state authorities, any professional dental society, accreditation agency or other governmental or non-governmental oversight entity? ☐ Yes ☐ No

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 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 Tennessee and Washington Residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont Residents only: which may be a crime and may be subject to civil fines and criminal penalties.)

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

_____

Signature in full: Date

REMINDER:

RETURN TO:

State Administrator Name:

_____

_____

Address:

_____

City: State: Zip Code:

_____

Phone #: (_____)_____

Agent's License Number: _____