Application for Newly Graduated Dental Students Entering Practice for the First Time

Type of Policy Requested: ☐ **Claims-Made** ☐ **Occurrence**

Complete all information as requested; use a "?" if you are not sure of an answer.

Limits **$1,000,000** per claim/**$3,000,000** aggregate (Higher limits available upon request)

Date you want your coverage to become effective _____ /_____ /_____ (Month Day Year)

Were you insured for your Board Exam through Brown/CNA Student Protector Plan? ☐ Yes ☐ No ☐ Not Sure

Your Name _____ (First Middle Initial Last Designation)

Mailing Address (Where we can reach you within the next 90 days)

_____ (Street)

_____ (City State Zip Code)

Phone Number (_____) _____ (Area Code) Day (_____) _____ (Area Code) Evening

E-mail Address _____

Date of Birth _____ / _____ / _____ (Month Day Year)

Education _____ (Dental School Attended Month/Year of Graduation)

History

Have you ever practiced before? ☐ Yes ☐ No (If "Yes", a full application must be completed prior to coverage approval. The application can be obtained from your State Administrator.)

Did you complete a residency? ☐ Yes ☐ No

Specialty:_____ Month/Year of Graduation: _____

Your Practice

☐ Endodontics ☐ Pedodontics ☐ Public Health
☐ General Dentistry ☐ Periodontics ☐ Faculty-Non Intramural
☐ Orthodontics ☐ Prosthodontics

Business Structure

☐ Sole Proprietor ☐ Partnership ☐ Employee
☐ Independent Contractor ☐ Other: _____

Practice Name and Address (list State if you don't know where you will be practicing)

_____ (Name)

_____ (Street)

_____ (City County State Zip Code)

(_____)_____ (Phone number (day)) (_____)_____ (Phone number (evening))

Risk Management

Have you taken one of the following risk management seminars? ☐ CNA ☐ Hartford ☐ AAO ☐ AAOMS ☐ Princeton ☐ NYSDA Date of attendance ____/____/____

☐ Yes, If "Yes", provide proof of attendance

☐ No, please send me information on how I can qualify for the risk management credit.

I hereby request that my application for insurance coverage under the provisions of the Professional Protector Plan® be submitted for consideration to the CNA Insurance Companies. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to the CNA Insurance Companies any and all information requested which may relate to my insurability under the Professional Protector Plan.

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 CNA to release the information on this application and associated underwriting information.

If you purchase a "Claims-Made" policy, the coverage will only respond to claims which are reported during the term of this policy. The "Claims-Made" coverage will not provide insurance coverage for claims which occurred prior to the "Prior Acts Date" of the policy.

If the "Claims-Made" policy with this insurance carrier is cancelled or non-renewed, or you decide to terminate it for any other reasons, and you 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, you will be able to purchase additional insurance coverage.

If you purchase an "Occurrence" policy, the coverage will only respond to claims which occur after the "Prior Acts Date" of this policy and before the end of the policy period, regardless of when the claims are reported.

If you have any questions, concerning the coverage for which you are applying, please contact your agent.

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.)

Signature in full: _____ Date: _____

RETURN TO:

State Administrator Name:
_____
_____

Address:
_____

City: State: Zip Code:
_____

Phone #: (_____)_____

Agent's License Number: _____