

CNA DENTAL PROGRAM

CLAIMS-MADE

Professional Liability Insurance For Dentists

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.
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 and any material misrepresentation could result in the voiding of coverage or cancellation of my policy.

LIMITS REQUESTED:		New Policy	Requested Effective Date: ____/____/____
<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$250,000/\$500,000		
<input type="checkbox"/> \$500,000/\$750,000	<input type="checkbox"/> \$750,000/\$1,000,000	Renewal of Policy Number: _____	
<input type="checkbox"/> \$1,000,000/\$3,000,000	<input type="checkbox"/> Other: \$ _____ / \$ _____ (STATE EXCEPTIONS: IN, SC)		

PLEASE TELL US ABOUT YOURSELF

1. Name: (First/Middle Initial/Last/Designation) _____	DDS DMD MD [BDS	2. Social Security Number: _____	3. Date of Birth: _____
4. Mailing Address: _____			
Street _____	City _____	State _____	Zip Code _____
5. Telephone Number: (____) _____	6. Fax Number: (____) _____	7. E-mail Address: _____	
8. Years in Practice: _____	9. Dental School Attended: _____	10. Month/Year of Graduation: _____	
11. Business structure under which you practice:			
A. Do you own your dental practice?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
B. Are you: <input type="checkbox"/> Incorporated <input type="checkbox"/> Partnership <input type="checkbox"/> L. L. C. <input type="checkbox"/> L. L. P. <input type="checkbox"/> Sole Proprietor			
• Provide the name of the Legal Entity _____			
C. Besides yourself, list the names of all dentists who are partners/corporate officers: (use a separate sheet if necessary) (Note: All partners/corporate officers must be insured by CNA)			
_____ Name	_____ Social Security No.	_____ Name	_____ Social Security No.
_____ Name	_____ Social Security No.	_____ Name	_____ Social Security No.
_____ Name	_____ Social Security No.	_____ Name	_____ Social Security No.
D. If you own your own practice, how many:		# of full-time	# of part-time
Employee dentists work for you?..... (Attach separate application or proof of professional liability insurance)		_____	_____
Independent Contractor dentists work for you?..... (Attach proof of professional liability insurance)		_____	_____
Other employees work for you? (other than dentists).....		_____	_____
Total			

- E. Do you work for another dentist as an independent contractor dentist?..... Yes No
If "Yes", at how many locations do you practice each week? _____
- F. Do you work for another dentist as an employee dentist?..... Yes No
If "Yes", at how many locations do you practice each week? _____
- G. Do you share dental facilities with another dentist other than employees or independent contractors?... Yes No
If "Yes", attach proof of professional liability insurance for the other dentists

ABOUT YOURSELF (continued)

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

Primary

1) _____

Street	City	County	State	Zip Code	%
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

13. Are you currently licensed to practice dentistry?..... Yes No
 State(s): _____
 Dental License #(s): _____
 DEA License #(s): _____

14. Indicate your Practice Specialty

<input type="checkbox"/> General Dentistry	<input type="checkbox"/> Pediatric Dentistry	<input type="checkbox"/> Oral/Maxillofacial Surgery *
<input type="checkbox"/> Endodontics	<input type="checkbox"/> Periodontics	<input type="checkbox"/> Anesthesiology(Dental)-Conscious Sedation *
<input type="checkbox"/> Oral Pathology	<input type="checkbox"/> Prosthodontics	<input type="checkbox"/> Anesthesiology(Dental)-General Anesthesia *
<input type="checkbox"/> Orthodontics		

* Supplemental Questionnaire must be completed

15. Which of the following procedures are performed by you:

<input type="checkbox"/> TMJ-Phase II (irreversible treatments such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)	<input type="checkbox"/> "Sargenti" or similar endodontic technique
<input type="checkbox"/> Implant Surgery	<input type="checkbox"/> Implant Restoration
<input type="checkbox"/> Extraction of Impacted teeth	<input type="checkbox"/> Molar Endodontics on Permanent Teeth
<input type="checkbox"/> Sleep Apnea Therapy*	<input type="checkbox"/> Weight Loss Therapy*
	<input type="checkbox"/> Botox, Restalyne, or Collagen Injections

*If Sleep Apnea or Weight Loss Therapy is performed, please indicate the following: (check all that apply)**
 Sleep Apnea: I fabricate snore guard I treat only after referral from physician I treat without physician referral
 Weight Loss: I treat only after referral from physician I treat without physician referral

16. Are you in compliance with OSHA and CDC Standards for infection control? Yes No

17. Do you use written consent forms prior to performing dental procedures?..... Yes No

18. Do you obtain oral informed consent prior to performing dental procedures?..... Yes No
 If Yes, do you document your records:
 Always Often Sometimes Rarely Never

19. A. Have you ever 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 suspended, revoked, or taken any other action against either your narcotics license or license to practice dentistry?..... Yes No
 If "Yes", provide a copy of the board transcript or other documentation, including resolution.

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

D. Have you ever been treated, or are you 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 USE OF ANESTHETICS AND ANALGESIA

Please be sure to read and answer all parts very carefully. For purposes of these questions, the following definitions of **Anxiety Reduction**, **Conscious Sedation** and **General Anesthesia/Deep Sedation** are provided:

- **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.”

20. A. Is your practice limited to the use of local anesthesia, oral medication and/or nitrous oxide?..... Yes No
 B. Are you treating patients who are under conscious sedation? Yes No
 C. Are you treating patients who are under general anesthesia / deep sedation?..... Yes No
 If “**Yes**”, where are the procedures performed? In your office In a hospital or surgical center
 If “**In Your Office**”, who administers the anesthesia? You Another Dentist, Anesthesiologist or CRNA

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

21. Are you now, or have you ever, practiced without professional liability insurance?..... Yes No
 If “**Yes**”, provide dates and reason:

22. Have you ever had any professional liability insurance refused, cancelled or non-renewed?..... Yes No
 If “**Yes**”, provide dates and reason:

23. Has any claim or suit for alleged malpractice ever been brought against you?..... Yes No
 If “**Yes**”, please complete Supplemental Claim form.

24. 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.

25. List prior carrier(s) for the past three (3) years. If none, state “None.”

Insurer	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability

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

27. Prior Acts date (Retroactive date) used by your previous carrier _____

28. Was an extended reporting endorsement (tail) purchased from your previous carrier?..... 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 group of 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 applies only to claims that are first made against the insured during the policy period. Claim expenses reduce the limit of liability. I also acknowledge that my "Claims-Made" coverage will not provide insurance coverage for acts or omissions 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 acts or omissions which may have occurred during the term of the "Claims-Made" policy, but no claim was made against me or reported to the insurance company before the date of the policy termination, I will be able to purchase additional insurance coverage for such acts or omissions.

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 Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to \$15,000.) (For Colorado, Tennessee and Virginia Residents only: Penalties may include imprisonment, fines, denial of insurance benefits and civil damages.)

Applicable in New York: Fines will not exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Colorado: Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant, for the purpose of defrauding or attempting to defraud the policyholder or claimant, with regard to settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

Signature in full:

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:		
Agent's Name:		

Address:		

City:	State:	Zip Code:

Phone #: (_____) _____		
Agent's License Number: _____		

Coverage is underwritten by Columbia Casualty Company, one of the CNA property/casualty insurance companies. CNA is a service mark registered with the US Patent and Trademark Office.