Dental Corporation Professional Liability Insurance Application

DentistCare℠

ProAssurance
Treated Fairly

ProAssurance Indemnity Company, Inc. • 3000 Meridian Blvd, Suite 400 • Franklin, TN 37067 • <<insert phone number>>

With your fully completed, signed and dated application, you must submit the following information:

1. Current insurance policy declarations page.
2. Copy of extended reporting endorsement (tail) from your current carrier if your current coverage is claims-made and you are *not* applying for prior acts coverage.
3. Loss runs from all prior insurance companies or explanation as to why they are not available.

1. Organization Information

Primary Operating Entity Name: _____

Federal Tax ID: _____-_____ Entity NPI Number: _____

Primary Office Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Preferred Billing Address: _____

Contact Name: _____ Title: _____

Phone: _____ Email: _____

Is this contact the authorized representative for access to policy information at the DentistCare website? Yes ☐ No ☐

If no, please provide the name of the policy's authorized representative: _____

A. Type of Corporation

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership

☐ Multi-Shareholder Corporation ☐ Limited Liability Corporation ☐ Other: _____

B. Is there more than one corporate entity that needs to be listed on the policy? Yes ☐ No ☐
If Yes, Please complete the Dental Corporation Additional Corporate Entity Information Form at the end of this application.

Please Note: For the purposes of this Application, the covered "Organization" will be defined as the Primary Operating Entity as well as any other entities listed on the Dental Corporation Additional Corporate Entity Information Form.

C. Has the Organization ever been incorporated under a name other than that listed above? Yes ☐ No ☐
If yes, please list all previous names and the first use date of each:

_____

D. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐
If yes, please list all d/b/a names:

_____

2. Coverage Information

A. Requested Effective Date: _____ / _____ / _____
MONTH DAY YEAR

B. Requested Limits[1]
   i. ☐ Shared Limits ☐ Separate Limits
   ii. If requesting separate limits:
      a. Primary Coverage Limits: _____
      b. Excess Coverage Limits: _____

C. Coverage Type: ☐ Claims-Made ☐ Occurrence

D. If Claims-Made coverage requested, is the Organization requesting Prior Acts Coverage? Yes ☐ No ☐
Requested Retroactive Date for the Primary Operating Entity: _____ / _____ / _____
MONTH DAY YEAR

Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by ProAssurance Indemnity Company that your request for Prior Acts Coverage has been approved.

3. Insurance History and Claims Information

Please provide a minimum of five years of coverage information if applicable.

A. Current Insurance Information (please indicate if none):
   i. Name of Insurer: _____
   ii. Policy Limits: _____ Shared ☐ Separate ☐
   iii. Dates Covered, From: _____ To: _____
   iv. Policy Type: ☐ Claims-Made ☐ Occurrence
   v. If Claims-Made, Retroactive Date: _____ / _____ / _____
   MONTH DAY YEAR
   vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Previous Insurance Information (please indicate if none):
   i. Name of Insurer: _____
   ii. Policy Limits: _____ Shared ☐ Separate ☐
   iii. Dates Covered, From: _____ To: _____
   iv. Policy Type: ☐ Claims-Made ☐ Occurrence
   v. If Claims-Made, Retroactive Date: _____ / _____ / _____
   MONTH DAY YEAR
   vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

C. Have any claims or suits ever been filed against the Organization? Yes ☐ No ☐

D. Are you aware of any conduct, circumstances, occurrences, or incidents likely to give rise to a claim? Yes ☐ No ☐

E. If you are answered "yes" to question 3.C. or D., have the claims, conduct, circumstances, occurrences, or incidents been reported to a previous insurer? (Please complete the Supplementary Claims information form at the end of this application.) Yes ☐ No ☐

F. Has the Organization ever been convicted of or pled guilty to or entered into a plea agreement for a violation of any law or ordinance? Yes ☐ No ☐
If yes, please provide comments in the Additional Comments section.

G. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes ☐ No ☐

[1] Limit options vary by state

4. Practice Information

A. Are there any advanced-level healthcare providers, members, shareholders, partners, owners, employed dentists or independent contractors in the Organization for whom a separate application has not been submitted for inclusion on this policy? If Yes, please complete the Dental Corporation Additional Individual Providers Form at the end of this application. Yes ☐ No ☐

B. Do you employ any of the following auxiliary staff? If yes, indicate the number in each category: Yes ☐ No ☐

Dental Hygienist: _____ Dental Assistant: _____ Dental Technician: _____

C. Are any auxiliary staff 1099 independent contractors? Yes ☐ No ☐

Fraud Warning – The Organization acknowledges the applicable fraud warning for its state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

On behalf of the Organization, I understand that no coverage will be bound until after ProAssurance has reviewed this completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, any advance payment will be promptly returned to the Organization.

On behalf of the Organization, I accept the following conditions during the processing and consideration of this application—regardless of whether or not granted insurance—and for the duration of the insurance which may be issued.

To the fullest extent permitted by law, I, on behalf of the Organization, extend absolute immunity to and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to this application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, and disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

The Organization understands that should any incident, injury or death occur to any patient while under our care subsequent to my signing and dating this application, we must notify ProAssurance or its authorized agent or broker in writing of such event.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Title: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Applicant's Representations and Authorization which requires your signature. Please read it carefully.

Applicant's Representations and Authorization

I, the undersigned, on behalf of the Organization, hereby authorize present and prior professional liability carriers, any and all attorneys who have represented us in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding the Organization, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon our acceptability to ProAssurance and its subsidiaries or agents as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

On behalf of the Organization, I understand that third-party information, records or data regarding our practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

On behalf of the Organization, I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

On behalf of the Organization, I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

On behalf of the Organization, I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Title: _____

Note: ProAssurance's Privacy Policy can be found at ProAssurance.com.

For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

Dental Corporation Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Name: _____
2. Date Reported to Insurance Company: _____
3. Name of Insurance Company: _____
4. Name and Address of the Attorney assigned to your case: _____
5. Date of Incident and your treatment: _____
6. Allegations: _____

   _____

   _____
7. What is the present condition of the patient? _____

   _____

   _____
8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes ☐ No ☐
9. Status of claim (check applicable answer):

☐ Suit threatened, no action taken	☐ Court outcome in your favor	☐ Awaiting mediation
☐ Suit filed, but dropped by claimant	☐ Jury verdict	☐ Awaiting court action
☐ Summary Judgment in your favor	☐ Directed verdict	Reserve Amount: _____
☐ Suit settled Out-of-Court	☐ Court outcome in favor of plaintiff	
Date claim paid: _____	☐ Jury verdict	
Amount paid: _____	☐ Directed verdict	
	Amount of Loss: _____	

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐
    If yes, amount was: $_____

Name (Printed): _____

Signature: _____ Date: _____

Dental Corporation Additional Corporate Entity Information Form

Coverage for additional operating entities is available on a shared limits basis subject to underwriting approval. If there is more than one additional corporate entity, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Organization Information

Additional Operating Entity Name: _____

Federal Tax ID: _____-_____

Primary Office Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

A. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐
If yes, please list all d/b/a names:

_____

2. Coverage Information

A. If Claims-Made coverage requested, is the Organization requesting Prior Acts Coverage? Yes ☐ No ☐
Requested Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by ProAssurance Indemnity Company that your request for Prior Acts Coverage has been approved.

Dental Corporation Additional Individual Providers Form

If there is more than one provider, please photocopy this form. Attach additional sheets if needed.

Please list all healthcare providers, members, shareholders, partners, owners, employed dentists and independent contractors in the Organization for whom a separate application has not been submitted for inclusion on this policy.

Name: _____ Please check any that apply:

Specialty: _____ ☐ Member ☐ Owner ☐ Shareholder

Start Date: _____ ☐ Employee ☐ Partner ☐ 1099 Independent Contractor

Current Insurer: _____ ☐ Other _____ Hrs/Week worked for the Organization

Practice Location: _____

1. Do you wish the Organization to have coverage for the vicarious liability exposure associated with this individual? Yes ☐ No ☐

   If Yes, please completed questions 2 through 5 and provide a currently valued certificate of insurance or declarations page that show limits of liability and coverage dates.

2. Does this provider perform any of the following procedures (Check all that apply):

   Oral Surgery: ☐ Minor (Alveolar) ☐ Major (other procedures)

   Extractions: ☐ Third Molar ☐ Full Impacted ☐ Partial Bony Impacted

   Implants: ☐ Initial Surgical Placement of Implants

   Endodontics: ☐ Multi-Rooted Endodontics

   Periodontics: ☐ Bone Grafts ☐ Soft Tissue Grafts

   ☐ This provider performs none of the above procedures.

3. Does this provider administer moderate or deep sedation, or general anesthesia? Yes ☐ No ☐

4. Has this provider had any professional liability claims in the last ten years? Yes ☐ No ☐

   If Yes, please provide ten years of currently valued loss runs.
   If No, please have this provide a signed a no known loss statement.

5. Has this provider had any board or license actions in the last ten years? Yes ☐ No ☐