Dental Professional Liability Insurance
Dentist 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. Personal Information

Name: _____ Degree: _____

Date of Birth: _____ Social Security Number: _____ Gender: Male ☐ Female ☐

Email Address: _____

Home Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Dental License Number(s):	State	License Number	Expiration Date	% of Practice
	_____	_____	_____	_____
	_____	_____	_____	_____

Individual NPI Number: _____

Professional Membership(s): ☐ ADA ☐ AGD ☐ AGD Fellowship ☐ AGD Mastership

2. Practice Location

Practice Name: _____

Practice Street Address: _____

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

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Billing Address: _____

Contact Name: _____ Title: _____

Contact Email Address: _____

Please list other practice locations:

Practice Name: _____

Practice Street Address: _____

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

Dates: _____ From: _____ To: _____ Percent of Practice: _____

Practice Name: _____

Practice Street Address: _____

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

Dates: _____ From: _____ To: _____ Percent of Practice: _____

3. Coverage Requested

A. Requested effective date: _____ / _____ / _____
MONTH DAY YEAR

B. Please indicate your desired level of coverage.
Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): _____ / _____
Excess Coverage Limits (where available): _____

C. Desired Coverage Form: ☐ Claims-Made ☐ Occurrence

D. Do you desire coverage for a practice entity? Yes ☐ No ☐
If yes, we require a corporate application to be completed. If no, please initial below:
☐ Please initial that by selecting "No", you acknowledge the requested policy will not provide coverage to any currently operated dental practice entities or entities formed after the effective date of coverage unless approved and endorsed onto the policy.

E. Do you contract with any person or entity that requires your Professional Liability policy to indemnify them and hold them harmless or name them as an "Additional Insured"? Yes ☐ No ☐
If yes, describe in the space provided at the end of the application.

4. Prior Acts Coverage (Claims-Made Only)

(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.)

A. Are you requesting Prior Acts Coverage? If no, please skip to Section 5. Yes ☐ No ☐
Requested Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

B. During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice (e.g., different states, procedures, coverages)? Yes ☐ No ☐
If yes, please describe the changes in your practice, including all applicable dates in the space at the end of the application.

5. Education and Training

A. Please list the name and location of all dental schools attended:

Institution and Location	Dates Attended	Degree Obtained

B. Please list any post-graduate training:

Institution and Location	Dates Attended	Degree Obtained

C. Have you completed a General Practice Residency? ☐ Yes ☐ No

D. Are you board certified in any specialty? ☐ Yes ☐ No
If yes, please list specialty or residency: _____

E. List first date of practice after graduating from dental school or completion of post-graduate training, if applicable. (This includes any moonlighting activities done during post-graduate training.) _____

6. Practice Information

A. Do you practice as (check one):
☐ Solo Unincorporated ☐ Partner in a Partnership ☐ Employee
☐ Solo Corporation ☐ Shareholder in a Professional Corporation ☐ 1099 Independent Contractor

B. Please check your present specialty:
☐ General Dentistry ☐ Pediatric Dentistry ☐ Endodontics
☐ Periodontics ☐ Oral or Maxillofacial Surgery ☐ Prosthodontics
☐ Orthodontics ☐ Oral Radiology ☐ Oral Pathology
☐ Dental Anesthesiologist ☐ Other (please specify): _____

C. Please check and indicate procedures you perform:

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

☐ None of the above procedures apply to your practice

D. Anesthesia/Sedation

1. Check the type of anesthesia and/or sedation used in your practice:

☐ Moderate Sedation (Parenteral) ☐ Moderate Sedation (Enteral)

☐ Deep Sedation ☐ General Anesthesia

*Please note: If you checked any of the above boxes, please complete the Dental Anesthesia Questionnaire.

☐ Please check here if none of the above apply to you and your practice is limited to local anesthesia, nitrous oxide and/or oral minimal sedation.

2. Are you or your staff certified in BCLS? ☐ Yes ☐ No

E. How many hours a week do you practice? _____ Date you established this schedule: _____ (MONTH) / _____ (DAY) / _____ (YEAR)

F. Do you teach in a dental school? ☐ Yes ☐ No
If yes, indicate the name of the school, how many hours per week and if coverage is provided through the dental school in the space provided at the end of the application.

G. Do you treat inmates in a correctional institution, treat patients via a mobile dental unit or treat patients in a nursing home facility? ☐ Yes ☐ No
If yes, list percent of your total practice time (additional supplements may be required):

- Correctional Institutions _____ %
- Mobile Dental Units _____ %
- Nursing Homes _____ %

H. Do you treat sleep apnea patients without a physician referral? ☐ Yes ☐ No

I. Do you perform any procedures that are clinical trials, experimental, not usual or customary to the specialty or that are not approved by the ADA or the FDA? ☐ Yes ☐ No
If yes, describe in the space provided at the end of the application.

J. Do you provide elective facial cosmetic procedures, Botox, collagen injections, or other dermal fillers for cosmetic purposes in your practice? ☐ Yes ☐ No
If yes, describe in the space provided at the end of the application.

K. Do you perform procedures outside the oral and maxillofacial region? ☐ Yes ☐ No
If yes, describe procedures and number provided per year in the space provided at the end of the application.

L. Do you provide forensics or expert witness testimony? ☐ Yes ☐ No
If yes, describe procedures and number provided per year in the space provided at the end of the application.

7. Insurance History and Claim Information

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

A. Current Insurance Information:

i. Name of Insurer: _____

ii. State Where Practiced: _____

iii. Policy Limits: _____

iv. Dates Covered, From: _____ To: _____

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. Retroactive Date: _____ (MONTH) / _____ (DAY) / _____ (YEAR)

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Previous Insurance Information:

i. Name of Insurer: _____

ii. State Where Practiced: _____

iii. Policy Limits: _____

iv. Dates Covered, From: _____ To: _____

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

C. Previous Insurance Information:

i. Name of Insurer: _____

ii. State Where Practiced: _____

iii. Policy Limits: _____

iv. Dates Covered, From: _____ To: _____

v. Policy Type: Claims-Made ☐ Occurrence ☐

vi. Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

vii. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

D. Will you be carrying additional liability insurance with another company? Yes ☐ No ☐

If yes, provide name of company, limits, expiration date, and services/practices covered:

_____

If you answer yes to questions E, F, or H, including any sub-questions, please complete the attached Supplementary Claims Information Form.

E. Have you *ever* been involved in a dental professional liability claim or suit? The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership. Yes ☐ No ☐

F. Other than the situations indicated in 7.E. above, are you aware of any of the following circumstances:

i. A request for records from a patient, family member, attorney, or patient representative related to an adverse outcome or treatment of a patient? Yes ☐ No ☐

ii. A letter from an attorney regarding your treatment of a patient? Yes ☐ No ☐

iii. A patient, family member, or patient representative's dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes ☐ No ☐

iv. Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes ☐ No ☐

G. Have all circumstances in question 7.F. above been reported to your current or prior professional liability carrier? Yes ☐ No ☐ N/A* ☐

If yes, how many? _____ Please attach documentation of all such reports.

If no, please explain in space provided at the end of the application.

*For purposes of this question, N/A means that you answered "No" to each subpart of question 7.F.

H. 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 ☐

8. Personal History

If you answer yes to any of the following questions, provide complete details in the space provided at the end of the application or on a separate sheet.

A. Have you ever been treated for alcoholism, drug addiction, sexual addition or mental illness? Yes ☐ No ☐

B. Are you or have you ever been in a treatment program for any health impairment or disability that may affect your ability to perform professionally? Yes ☐ No ☐

C. Have you ever been convicted of, pled guilty to, or pled no contest to a felony or violation of any law or ordinance (other than minor traffic offenses), including driving while under the influence of alcohol or any other substance? Yes ☐ No ☐

D. Has your license to practice dentistry or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered or otherwise investigated or limited in any way? Yes ☐ No ☐

E. Have you ever appeared before, had a grievance or complaint filed with, been investigated by or entered into any consent agreement with any State Licensing Board, Board of Dental Examiners, dental review committee or hospital committee? Yes ☐ No ☐

F. Have you ever voluntarily surrendered your hospital privileges or narcotics or professional license to avoid suspension, restriction, probation or revocation? Yes ☐ No ☐

G. Has any hospital ever restricted, suspended, revoked or refused your privileges or placed you on probation? Yes ☐ No ☐

H. Have you ever been accused of sexual misconduct or inappropriate physical contact? Yes ☐ No ☐

Dentist's 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: _____

Dentist's Anesthesia Questionnaire

Completion of this supplemental anesthesia questionnaire is required based on answers provided on your application for dental professional liability coverage. Please be advised that all information disclosed on this form is subject to the anti-fraud statement contained on the initial application.

Dentist's Name: _____

Please indicate the type of anesthesia/sedation used in your practice:

☐ Oral Moderate Sedation

Administered in: ☐ Office ☐ Hospital ☐ Other (Please Explain) _____

Administered by: ☐ Myself ☐ Oral Surgeon ☐ Anesthesiologist/CRNA ☐ Other (Please Explain) _____

☐ IV/IM Moderate Sedation

Administered in: ☐ Office ☐ Hospital ☐ Other (Please Explain) _____

Administered by: ☐ Myself ☐ Oral Surgeon ☐ Anesthesiologist/CRNA ☐ Other (Please Explain) _____

☐ Deep Sedation/General Anesthesia

Administered in: ☐ Office ☐ Hospital ☐ Other (Please Explain) _____

Administered by: ☐ Myself ☐ Oral Surgeon ☐ Anesthesiologist/CRNA ☐ Other (Please Explain) _____

1. Do you have all state-required permits/licenses for the level of anesthesia/sedation administered by yourself? ☐ Yes ☐ No
2. Are you in compliance with all State Board rules and regulations in the state you are administering sedation/anesthesia? ☐ Yes ☐ No
3. Do you utilize informed consent documentation prior to all sedation/anesthesia procedures? ☐ Yes ☐ No
4. Do you administer anesthesia to patients outside the practice for which you are applying for coverage? ☐ Yes ☐ No

   If yes, please explain: _____
5. Do you adhere to the American Dental Association Guidelines for the Use of Sedation and General Anesthesia by Dentists[1] and the American Academies of Pediatrics and Pediatric Dentistry's Guidelines for Monitoring and Management of Pediatric Patients[2] for the pre-anesthesia evaluation, intra-operative monitoring, and post-anesthesia care? ☐ Yes ☐ No
6. Please indicate the types of equipment/supplies available and properly maintained in your office:

   ☐ ECG ☐ BP Monitor ☐ Positive-Pressure Oxygen Source ☐ Suction Apparatus
   ☐ AMBU Bag ☐ IV Set-up ☐ Intubation Equipment ☐ Capnograph
   ☐ Inhalation / Scavenging System ☐ Pulse Oximeter ☐ Back-up Power Source ☐ Defibrillator
   ☐ Temperature Monitor ☐ Resuscitative & Emergency Drugs[3] (Crash Cart)
7. Please indicate if you are certified in any of the following:

   ☐ ACLS ☐ PALS ☐ ATLS
8. Do you keep detailed time-based monitoring records for each procedure? ☐ Yes ☐ No
9. Are written discharge instructions given to a responsible adult with a copy maintained in the dental record? ☐ Yes ☐ No
10. Does the record contain documentation that the patient was discharged to an adult for transportation? ☐ Yes ☐ No

Name (Printed): _____

Signature: _____ Date: _____

[1] American Dental Association "Guidelines for the Use of Sedation and General Anesthesia by Dentists". Adopted by the ADA House of Delegates, October 2016.
[2] American Academy of Pediatrics and American Academy of Pediatric Dentistry, "Guidelines for Monitoring and Management of Pediatric Patients Before, During and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016."
[3] Includes age appropriate ACLS and PALS drugs and reversal agents in case of emergency.

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I understand that no coverage will be bound until after ProAssurance has reviewed my 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, my advance payment will be promptly returned to me.

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me.

To the fullest extent permitted by law, I 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 my 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.

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

Name (Printed): _____

Applicant's Signature: _____ Date: _____

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 Representation and Authorization which requires your signature. Please read it carefully.

Applicant's Representation and Authorization

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

I understand that third-party information, records or data regarding my practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

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.

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.

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: _____

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

For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments