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DENTAL ANCILLARIES PROFESSIONAL LIABILITY INSURANCE RENEWAL APPLICATION

Section I – General Information (All questions must be completed.)

1. Name of applicant: _____

Address: _____

2. Contact person: _____ Phone: _____ Fax: _____

3. Birth Date: _____ E-Mail: _____

4. List any **new** locations since your last application:

5. Provide the average number of hours and number of patients worked/seen per week: _____ # Hours _____ # Patients

6. Do you practice as:
 Dental Assistant Dental Hygienist Dental Lab Technician Other

7. List any **new** states in which you have been licensed or certified since your last application.

State	License#	Certificate#	% per state	% of patients	% of hospital

8. Are you currently aware of any investigation being conducted which could impact your license? Yes No

9. Provide detailed description of any changes in your principal activity while working since your last application.

10. Have you received any communication/request for information from an attorney, a court of law, patient, patient family member or patient representative regarding medical services you performed **or** have any claims or suits for alleged malpractice been brought against you **or** are you aware of any circumstances, medical incidents or records requests that may give rise to a claim or a suit? Yes No

If “yes” to any of the above, please provide a separate narrative describing the nature of the communication or occurrence.

11. Do you follow all state laws, federal laws and specific national association protocols? Yes No
 If “No”, please explain and attach a copy of the protocols followed or changed since your last application.

Section II – Signature: This section must be completed by all applicants.

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind CARE Professional Liability Association, Inc. to complete the insurance, but it is agreed that this application shall be the basis of a contract should a policy be issued. I authorize, release any exchange of any underwriting or claims information between all prior carriers and CARE Professional Liability Association, Inc.

Notice to Kentucky Applicants: Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Signature of Applicant _____ Date: _____

I understand that CARE Professional Liability Association, Inc. reserves the right to reject any applicant that does not meet its Underwriting standards.

Policy Number _____ **Renewal Date:** _____