PROFESSIONAL LIABILITY ASSOCIATION, LLC
CARE RISK RETENTION GROUP, INC

9300 Shelbyville Rd., Suite 204 Louisville, KY 40222 (v)502.895.6404/866.749.2273 (f)502.895.6406/866.797.2273

DENTIST RENEWAL APPLICATION

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

1. Name of applicant: _____

   Office Address: _____

   Mailing Address (if different from above): _____

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

3. 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:
   ☐ General Dentistry ☐ Orthodontics ☐ Oral Surgery ☐ Periodontics

   ☐ Other (Describe) _____

7. Do you perform any procedures using general anesthesia or IV/conscious sedation? ☐ Yes ☐ No

8. Do you administer Botox or any injectable aesthetics? ☐ Yes ☐ No

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

State	License #	Certificate #	% of practice in new state	% of patients in new state	% of hospital practice in new state

10. Are you currently aware of any investigation being conducted which could impact your license? ☐Yes ☐No (If "yes", please attach explanation.)

11. Provide detailed description of **<u>any changes</u>** in your principal activity while working since your last application. If none, please indicate, "none".

    _____

12. 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.

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, LLC* 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, LLC.*
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, LLC* reserves the right to reject any applicant that does not meet its Underwriting standards.

Policy Number _____ Renewal Date:_____