PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

Application Checklist

- ☐ Complete Application
- ☐ Completed claim form for every previous medical malpractice claim
- ☐ Curriculum Vitae
- ☐ Declaration sheet from your current carrier
- ☐ Copy of your license(s)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions; if a question is not applicable, state "NOT APPLICABLE".
2. If Space is insufficient to answer any questions fully, attach a separate sheet.
3. The Application must be signed and dated by the applicant.
4. It the answer to any question is none, state "NONE".
5. Please do not complete the application earlier than 60 days before proposed effective date of coverage.

Preparers Signature x_____ Date _____

Submitted by:
Agency: _____

Address: _____

City: _____ State_____ Zip _____

Revised 5-2014

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR DENTISTS

THIS IS FOR A CLAIMS MADE AND ASSERTED POLICY

(PLEASE PRINT IN INK)

1. A. Full Name of Individual Applicant: _____

   B. Date of Birth _____ Place of Birth _____ SS# _____

   C. Are you a U. S. Citizen? ____ If "no" please indicate your status and entry into USA on separate sheet. Include a copy of your current Permanent Visa

   D. Email address _____

   *We will not sell, license, transmit or disclose your email information outside of CARE

2. A. Principal Office Address

   Street: _____

   City/State/Zip: _____

   County: _____ Phone # _____

   Contact Person: _____

   B. Mailing Address: (All correspondence from CARE will be sent to the principal address unless otherwise noted)

   Street: _____

   City/State/Zip: _____

   County: _____ Phone # _____

   C. Residence Address:

   Street: _____

   City/State/Zip: _____

   County: _____ Phone # _____

   D. Other Offices (Please attach a separate sheet for additional office locations)

   Street: _____

   City/State/Zip: _____

   County: _____ Phone # _____

3. Limits of Liability desired: _____
   (Limits in policy will govern coverage)

4. Desired Effective Date (12:01 a.m.): _____
   Desired Retroactive Date (12:01 a.m.) _____ (attach current policy evidence if coverage is desired.)

5. I practice as: _____ Solo Practitioner (unincorporated) _____ Professional Corporation
_____ Solo Practitioner (incorporated) _____ Partnership
_____ Professional Corporation
_____ Employee of (name): _____
_____ Other (Describe) _____

6. If you practice other than as an <u>employee</u> or an unincorporated solo practitioner:

A. List the names of ALL your partners, your employees or members of your professional association or corporation who practice medicine and their current insurance carriers:

_____

_____

_____

_____

_____

B. Provide the formal corporate, association, partnership or business name and Tax ID #:

_____

C. Would you like coverage for the above entity? ____Yes _____ No

7. List all states where you are licensed to practice:

State _____License #_____ Permanent or Temporary? _____

State _____License #_____ Permanent or Temporary? _____

State _____License #_____ Permanent or Temporary? _____

If licensed in additional states please attach a separate sheet of paper.

8. A. List hospitals at which you are currently a staff member and show % of work at each hospital.

_____ % _____

_____ % _____

_____ % _____

B. Briefly describe type and extent of your hospital privileges:

_____
_____
_____

_____ Temporary _____ Permanent

C. Are you Chief or Head of a hospital department? _____ Yes _____ No
If yes, please explain in detail. _____

CURRENT PRACTICE

9. Dental Specialty:
   [ ] General Dental Practice [ ] Orthodontics [ ] Endodontics [ ]Periodontics

   [ ] Oral and Maxillofacial Surgery [ ] Other (describe) _____

   Average weekly patient load (number of patients seen):

   This calendar year (projected) _____Last calendar year_____ Calendar year before ____

   Number of hours practiced weekly:

   This calendar year (projected) _____Last calendar year_____ Calendar year before ____

Any practice outside of office location: ____ Yes ____ No.

If yes, where? _____

A. Number of years at current office location: _____

B. Have there been any significant changes in your practice during the past 5 years, i.e. changes in specialty, changes in location, addition or deletion of procedures, etc. ☐ Yes ☐ No If "Yes", please explain:

_____

DENTAL PROCEDURES

10. Check the following procedures which you perform.
    - [ ] Orthodontics
    - [ ] Extractions of impacted teeth
    - [ ] Root canals
    - [ ] Implants
    - [ ] Oral surgery or assisting in oral surgery. (Describe) _____

11. Do you administer analgesia? [ ] Yes [ ] No

    If Yes, please list types of analgesia used: _____

    _____

12. Do you administer IV/IM conscious sedation? [ ] Yes [ ] No

13. Do you or an employee of yours administer general anesthesia? [ ] Yes [ ] No

    If Yes:

    a) Is the general anesthesia administered
       i. In a dental office [ ] Yes [ ] No
       ii. In a hospital [ ] Yes [ ] No
       iii. In another type of facility [ ] Yes [ ] No

    Please explain:

    _____

b) Please list types of anesthesia used:

_____

_____

_____

_____

14. Do you administer general anesthesia to patients of other dentists? [ ] Yes [ ] No

If yes, please explain: _____

15. Do you administer anesthesia to non-dental patients? [ ] Yes [ ] No

If yes, please give details, including any special training you have pursued to qualify you for this work:

_____

_____

16. Do you perform any procedures on any patients under general anesthesia? [ ] Yes [ ] No

Do you perform any procedures on any patients under under IV/IM conscious sedation? [ ] Yes [ ] No

17. Do you wire jaws closed for the purpose of restricting food intake? [ ] Yes [ ] No

18. Do you do full mouth rehabilitation solely for cosmetic purposes? [ ] Yes [ ] No

19. Does our practice include:

Plastic Surgery? [ ] Yes [ ] No If "yes", please fill out the Plastic Surgery Supplement.

Any kind of aesthetic procedures? [ ] Yes [ ] No If "yes", please fill out the Aesthetics supplement.

20. A1. Indicate number of hours per month devoted to hospital emergency room care: _____

A2. Is this emergency room care:
1. On your own patients only? _____
2. Required for staff privileges? _____
3. Other (details) _____

STAFFING

21. A. List number and type of professional employees: **If none, check here:** ☐

_____ Dentists (other than yourself) _____ Oral Surgeons

_____Orthodontists _____ Nurses

_____Nurse Anesthetists _____ X-ray/Lab/or Dental Technicians

_____ Dental Hygienists _____Other: _____

B. Are all of the above individuals licensed in accordance with applicable state and federal regulations?

_____ If "no", attach explanation.

22. ATTACH DETAILED EXPLANATION FOR ANY "YES'. ANSWERS:

Have you or any of the above employees:

A. Ever been the subject of investigation or disciplinary proceedings or reprimand by a governmental or administrative agency hospital or professional association? _____

B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? _____

C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment? _____

D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? _____

E. Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? _____

F. Ever failed any dental licensing or specialty organization examination? _____

G. Have any chronic physical illness or defect? _____

H. Do you administer botox for therapeutic purposes? _____

I. Do you administer botox for cosmetic reasons only? _____

23. Do you supervise any individuals other than your own employees? _____ If "yes" provide a detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also indicate, by profession the number of individuals supervised.

NUMBER TYPE OF PROFESSION

_____ _____

_____ _____

_____ _____

24. Are you in the employ of any individual, firm or corporation other than your own? _____
If yes, attach explanation, including details of any responsibilities.

25. Are you under contract to any individual, firm or corporation other than your own? _____
If yes, attach explanation including details of your responsibilities. If this contract contains a hold-harmless agreement, a copy of the contract must be attached to the application.

26. Are you in the employ of any governmental entity? _____
If yes, attach explanation, including details of your responsibilities.

27. Are you under contract to any government entity? _____
If yes, attach explanation, including details of your responsibilities.

28. A. Do you advertise your professional services in any manner (other than a simple listing in the telephone directory)? _____

B. Are you associated with any agency or organization that engages in any kind of advertising for solicitation of patients? _____ If 'yes' submit copy of ALL the advertisements.

EDUCATION

29. A. From what dental school did you graduate? _____
Degree: _____ Year: _____
Location of Dental School (City, State, Country) _____

C. Residency? _____ If "yes" complete the following for each residency served:

D. Additional Training? _____ If "yes" complete the following:

Location _____ From _____ To _____ Type _____

E. Are you certified by an approved specialty board ? ____ If so, what specialty_____

Date certified: _____ Date Recertified: _____

WORK HISTORY

30. Did you practice with other dentists in an employer-employee relationship, ostensible or formal partnership, dental association or dental corporation during the period for which you are requesting Prior Acts Coverage? ☐ Yes ☐ No

If "yes", list the full name(s) of the entity(ies) and physician(s) with whom you practiced and the period of each such association. Attach additional pages as needed.

NAME OF ENTITY(IES)	NAME OF PHYSICIAN(S)	FROM TO

CHANGES IN PRACTICE:

Was your practice during the period for which you are requesting Prior Acts Coverage different in any way from your practice as described in this application for Dental Professional Liability Claims-Made Coverage? For instance, did your practice formerly include emergency room services that you are no longer providing or did you ever perform implants of any kind? ☐Yes ☐ No

Did any of your policies contain any coverage restrictions? ☐ Yes ☐ No

If "yes", please describe, including all applicable dates. Attach additional pages as needed.

_____

_____

31. Indicate membership in professional societies:

_____

_____

_____

32. Have you participated in any continuing dental education program within the past five years? _____

If yes, describe :_____

_____

_____

33. Do you or the firm named in Question 6. B. above own or operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? _____

If yes, describe_____

_____

_____

34. 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.

Total Number of Claims brought against you_____ # Open/Reserved_____ # Closed_____

Have you reported all claims and circumstances that might reasonably lead to a claim or suit to your current carrier? ❒ Yes ❒ No

35. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? _____
IF "YES" A SUPPLEMENTAL CLAIM INFORMATION FORM MUST BE COMPLETED FOR EACH INCIDENT.

36. List prior professional liability insurance carried for each of the past ten years. IF NONE, STATE NONE.

Insurer	Policy #	Policy Limit	Deductible	Premium	Inception	Expiration	Claims Made or Occurrence

37. What is the retroactive exclusion date on your current policy? _____

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on Page 1 of this application to (present date) have been reported to my current insurance carrier.

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to the Company prior to the effective date of such coverage and are listed previously or by supplemental form attached below.

WARRANTY

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy coverage excess of this policy.

Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains to my background, competence and qualifications.

APPLICANT (Signature Required) _____ Date: _____

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force. Furthermore the policy includes the cost of defense of claims within the policy limit which means that the Policy limit available to pay a claimant WILL be reduced by the cost of investigation, defense and other expenses involved in the defense. The applicant, by signing this application below confirms (his/her) understanding of all provisions represented by the Insurer.

Signature of Applicant_____Date_____

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Professional Liability Claims Information

(Must be printed or typed)

Complete one form for each case. Copies may be made as needed

Insurance Carrier: _____**Patient Name**_____

Date of Occurrence: _____ **Date of Suit**: _____

Location of Incident: _____

Relationship to Patient (attending physician, surgeon, consultant, etc.)

_____

Primary Defendant: _____ **Co-Defendant**: _____

Patient Outcome: _____

_____

Allegations made about care rendered: _____

_____

_____

_____

_____

Claim Status (Open, Closed, Pending): _____ **Date**: _____

If closed, indicate method of closing: **(Circle below)**

DISMISSAL SETTLED JUDGMENT CASE-DROPPED

Amount of settlement/judgment: _____ Date: _____

Dentist (print name): _____ Date: _____

I understand that the information submitted here becomes a part of my insurance application and is subject to the same representations and conditions.

Signature of Applicant: _____ Date: _____