

The Professional Protector Plan®

Claims-Made

Professional Liability Insurance For Dentists



THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS, AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant in ink.
3. A copy of your letterhead must be included.

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued. Additional Information may be required upon review of the application

I agree that any coverage issued will be contingent upon the truth of the following information:

New Policy: Requested Effective Date: _____ Rewrite of Policy Number: _____

PLEASE TELL US ABOUT YOURSELF

1. Full Name: _____ DDS DMD MS MD BDS

2. Mailing Address: _____

City/ State / ZIP: _____

3. Email Address: _____ 4. Web Site: _____

Please check this box if you would like "Dental Expressions" (CNA's quarterly Risk Management Newsletter) sent via email

5. Telephone Number: _____ 6. Fax Number: _____

7. Dental School Attended: _____ 8. Month/Year of Graduation: _____

9. Did you complete a residency? Yes No If "Yes" Specialty: _____

Month/year of Completion: _____

10. Are you entering practice for the first time? Yes No

11. Date of Birth: _____ 12. Years in Practice: _____

13. Are you currently licensed to practice dentistry? Yes No State(s): _____

License #(s): _____

POLICY REQUEST INFORMATION – PROFESSIONAL LIABILITY

14. Limits Requested:

- \$ 1,000,000 / \$ 3,000,000 \$ 2,000,000 / \$ 3,000,000 \$ 2,000,000 / \$ 4,000,000 \$ 2,000,000 / \$ 6,000,000
 \$ 3,000,000 / \$ 3,000,000 \$ 3,000,000 / \$ 6,000,000 \$ 4,000,000 / \$ 4,000,000 \$ 5,000,000 / \$ 5,000,000
 \$ 5,000,000 / \$,8, 000,000 Other: _____ STATE EXCEPTIONS MAY APPLY)

PLEASE TELL US ABOUT YOUR PRACTICE

15. Under which business structure do you practice?

Sole Proprietor Incorporated Partnership Limited Liability Company Limited Liability Partnership

Employee Dentist Name of Employer/Facility: _____

Independent Contractor Name of Employer/Facility: _____

Faculty Name of Employer/Facility: _____

Volunteer Name of Employer/Facility: _____

Will you receive remuneration for your volunteer services? Yes No

If you own your practice, please complete the following (A - E):

A. Name of your legal entity (if any): _____

B. Is the sole function / purpose of this entity for the practice of dentistry? Yes No
If no, please provide details (attach a separate sheet if necessary): _____

C. Do you desire **Shared** or **Separate** limits of liability to apply to our legal entity?
 Shared (limits are shared with you at no cost)
 Separate (entity has its own set of limits and an additional charge applies)

D. Excluding yourself, name all officers or partners of your legal entity: _____

E. Please provide the number of the following who work for you:

Employee Dentist (other than yourself and / or partners/corporate officers) * _____

Independent contractor dentists * _____

Other dentists sharing facilities with you who are **not** covered under this policy) * _____

* **NOTE: For any of the ABOVE 3 selections**, be sure to attach a separate application or proof of professional liability coverage for each

All other employees (hygienists, assistants, technicians, clerical, etc.) _____

16. Practice Address and Percentage of Practice at each Address (Total of Percentage Must Equal 100%)

Primary Address: Street City County State Zip %

Secondary Address: Street City County State Zip %

Additional Address: Street City County State Zip %

17. How many hours per week do you practice (include lab work, patient visitation and consultation)? _____
If 20 hours or less, please complete a Part-time Supplement

PLEASE TELL US ABOUT YOUR SPECIALTY

18. Indicate your Practice Specialty (please check all that apply)

- General Dentistry
- Dental Radiologist
- Periodontics
- Endodontics
- Anesthesiology (Dental)-General Anesthesia
- Full-time Faculty-Non-Intramural
- Prosthodontics
- Oral/Maxillofacial Surgery
- Orthodontics
- Anesthesiology (Dental)-Conscious Sedation
- Public Health
- Oral Pathology
- Pediatric Dentistry
- Oral Radiology

PLEASE TELL US ABOUT THE PROCEDURES PERFORMED IN YOUR PRACTICE

19. Which of the following procedures are performed by you or by someone under your supervision / direction?

- Sleep Apnea Therapy If "**Yes**", please indicate the following:
 - I treat only after referral from physician
 - I treat without physician referral
 - I fabricate oral appliances for treatment of severe snoring & / or obstructive sleep apnea
- "Sargenti," paste fill or formaldehyde based endodontic techniques **EXCLUDING** formocresol primary tooth pulpotomies
- IRREVERSIBLE** TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)
- Implant Surgery Extraction of Impacted teeth Implant Restoration Molar Endodontics on Permanent Teeth
- NONE OF THE ABOVE**

20. Is the following performed by you or by someone under your supervision / direction ? Cosmetic **dermal** procedures (including but not limited to Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.) Yes No

If "**Yes**", please provide an explanation on a separate sheet of paper

PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA

Anxiety Reduction is defined as "the use of nitrous oxide / oxygen and/or oral premedication used in an accepted therapeutic dose to reduce anxiety".

Conscious sedation is defined as "A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal commands, produced by a pharmacologic or non pharmacologic method, or combination thereof"

General Anesthesia and Deep Sedation are defined as "A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposely to physical stimulation or verbal command, produced by a pharmacologic method, or a combination thereof"

21. Are you treating patients who are under general anesthesia / deep sedation in your office ? Yes No

If 'YES' who administers, the anesthesia?

You

Another Dentist, Anesthesiologist or CRNA (please provide proof of Professional Liability Coverage)

PLEASE TELL US ABOUT YOUR DENTAL LABORATORY / DENTAL IMAGING SERVICES

22. Do you operate a dental laboratory? Yes No

If "**Yes**" do you accept referrals for other than your patients? Yes No

If "**Yes**" is there a separate business entity / corporation for this purpose ? Yes No

23. Do you provide radiology services for other than your patients or on a referral basis? Yes No

if "**Yes**" is there a separate business entity / corporation for this purpose ? Yes No

PLEASE TELL US ABOUT YOUR PARTICIPATION

24. Are you a member of your state dental association or society? Yes No

25. Have you taken one of the following risk management seminars in the last 3 years? Yes No

CNA (Evidence not required if you are a CNA insured)

AAOMS/ OMSNIC

AAO

NYSDA / DSSNY

Henry Spenadel

Date of Attendance ___/___/____ If "**Yes**", provide evidence of attendance

PLEASE TELL US ABOUT YOUR LICENSE AND CLAIMS HISTORY

26. A. Have you had a change in the status of your hospital privileges? Yes No

If "**Yes**", provide details on a separate sheet of paper.

B. Has any governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions? Yes No

If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.

C. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency? Yes No

If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.

D. Have you been convicted of any criminal charges? Yes No

If "**Yes**", provide details from investigating agency.

E. Have you ever been or are you currently being treated for:

Alcoholism Yes No

Drug Addiction Yes No

Mental Illness Yes No

Physical Impairment? Yes No

If "**Yes**", provide a letter from treating physician with complete details.

F. Are you now, or have you ever, practiced without professional liability insurance? Yes No

If "**Yes**", provide details on a separate sheet of paper.

G. Have you ever had any professional liability insurance refused, cancelled or non-renewed? Yes No

If "Yes", provide details on a separate sheet of paper.

THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS

H. Has any claim or suit for alleged malpractice ever been brought against you? Yes No

If "Yes", please complete Supplemental Claim form.

I. Are you currently aware of any situation that could lead to a malpractice suit against you? Yes No

If "Yes", please complete Supplemental Claim form.

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

27. List prior insurance carrier(s) for the past **three (3)** years. If none, state "None" and the reason.

Insurance Carrier	Eff Date	Exp Date	Claims-made or Occurrence	Limits of Liability

28. Are you applying for prior acts coverage from CNA? Yes No

If "Yes," please attach a copy of your last declarations page (face sheet).

29. Prior acts date (Retroactive date) used by your previous carrier: _____

30. Was an extended reporting endorsement (tail) purchased from your previous carrier? Yes No

PLEASE TELL US ABOUT YOUR GENERAL LIABILITY NEEDS

31. GL Limits are equal to your Professional Liability Limits but state exceptions may apply

32. Do you desire Shared or Separate Limits of liability to apply to each location:

Shared (Limits are Shared with each location at no additional cost)

Separate (each location has its own set of limits and an additional charge applies)

33. Have you had any general liability losses in the past **three (3)** years? Yes No

If "Yes", provide date(s) of loss and detail(s) _____

34. Do you desire ERISA Fiduciary Liability Coverage / Employee Benefits Liability? Yes No

Coverage is recommended if you sponsor any Employee Benefit Plan. This is NOT the bond for your pension plan. Coverage is written on a Claims-made basis.

If "Yes", check the desired Limits of Liability:

\$ 100,000 \$ 250,000 \$ 500,000 \$ 750,000 \$ 1,000,000

35. If you are a tenant would you like to increase the standard \$ 500,000 Fire / Water / Legal Liability Limits? Yes No

If "Yes", check the desired Limits of Liability: \$ 750,000 \$ 1,000,000

36. If your equipment lease or rental requires you to name the equipment lessor as an additional insured, please provide the name and address of the lessor as it appears on the lease or rental agreement.

37. If your building lease requires the building owner to be included as an additional insured for the portion of the premises leased to you, please list the Lessor's name and address as it appears on your lease:

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

I understand that my Professional Liability Coverage will be written on a "Claims-Made form" and acknowledge that this coverage will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" coverage will not provide insurance coverage for claims which occurred prior to the "Prior Acts Date" of my policy.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (For District of Columbia residents only: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.) (For Florida residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) (For Louisiana residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) (For Maine residents only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.) (For New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Oklahoma residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) (For Pennsylvania residents only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.) (For Puerto Rico residents only: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.) (For Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Oregon and Vermont residents only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) (For Washington residents only: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.)

RE M I N D E R

- Copy of letter head
- Part time supplement – if requesting part time credit
- Evidence of Risk Management attendance – if requesting RM credit
- "Yes" responses to certain questions require attachment of additional documents, are these attached ?
- Claim supplemental form must be completed for each claim, incident and / or suit in which you have been involved in
- Copy of prior carrier dec page – if applying for prior acts coverage

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

Signature in full:

Date

<p>RETURN TO:</p> <div style="text-align: center;"><p>MDA Insurance</p><p>3657 Okemos Road, Suite 100 Okemos, MI 48864 (800) 860-2272 Fax: (517) 484-5460 www.mdaprograms.com</p></div>
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