

NEW _____
RENEWAL OF POLICY NUMBER _____
ADD'L DENTIST TO POLICY NUMBER _____

DENTIST'S PROFESSIONAL LIABILITY APPLICATION



- The Cincinnati Insurance Company
- The Cincinnati Casualty Company
- The Cincinnati Indemnity Company

SECTION I - GENERAL INFORMATION

- 1. How is the policy named insured to read?
Is this an [] individual [] partnership [] corporation [] LLC [] LLP [] other:
2. Mailing Address:
Office Address: Phone Number: ()
Website:

SECTION II - CLAIMS INFORMATION

Please fully explain any "Yes" answers to the following questions in the space provided for "Remarks".

- 1. Have you or any of your employees had a claim made or suit brought for actual or alleged malpractice, error or mistake in the past five years?
2. During the past five years, has any insurer cancelled any similar insurance issued to you or declined to issue such insurance? (N/A in MO)

SECTION III - DENTIST INFORMATION - SEPARATE APPLICATION TO BE COMPLETED BY EACH DENTIST

- 1. Name of applicant:
2. If employed, by whom and in what capacity?
3. List university or college from which you graduated:
Degree: Year: Date you received state or regional board certification:
4. State(s) you are licensed in:
5. State(s) that you practice in: (IN only Professional License No.)
6. Are you a specialist? [] Yes [] No If "Yes", please describe:
School certified by: Date certified:
7. Do you meet the continuing education requirements of your state? [] Yes [] No If "No", please explain in the space provided for "Remarks".
8. How many total hours per week at all locations, do you practice?

SECTION IV - COVERAGE INFORMATION

- 1. Effective dates: From: To:
2. Please indicate limits of insurance by checking appropriate option:
A \$100,000 / 300,000
B \$200,000 / 600,000
C \$300,000 / 900,000
D \$500,000 / 500,000
E \$500,000 / 1,000,000
F \$1,000,000 / 1,000,000
G \$1,000,000 / 2,000,000
H \$1,000,000 / 3,000,000
I \$2,000,000 / 4,000,000
J \$2,000,000 / 6,000,000

Indiana License/Location: If Multi-Jurisdiction Endorsement is to apply, please complete the following:
"Designated Jurisdiction" Limits*: Each Dental Incident Limit Aggregate Limit
"Any Other Jurisdiction" Limits: Each Dental Incident Limit Aggregate Limit
*Jurisdiction subject to Patient's Compensation Fund, which limits applicant's financial liability.
3. Please indicate if umbrella coverage is desired: [] Yes [] No If "Yes", please complete an umbrella application.
4. Is your expiring policy a "claims-made" policy? [] Yes [] No If "Yes", prior acts coverage may be needed.
5. a. Do you desire prior acts coverage? [] Yes [] No If "Yes", please complete SECTION VII.
b. If "No", have you purchased an extended reporting period endorsement from your prior carrier? [] Yes [] No

SECTION V - PRACTICE INFORMATION

1. Please fully explain any "Yes" answers to the following in the space provided for "Remarks":

Yes No

- a. Has any dental or state licensing authority ever revoked, suspended or imposed any restrictions on your license, disciplined you, reprimanded you or placed you on probation? Yes No
- b. Do you have any current hospital staff appointments or privileges? Yes No
If "Yes", please forward a copy of your Delineation of Privileges form.
- c. Have you had hospital privileges granted, denied or revised? Yes No
- d. Has your membership in a dental association ever been revoked or suspended? Yes No
- e. Do you perform any procedures which have been introduced to the practice of dentistry within the last two years? Yes No
- f. Have you ever had a case brought against you in peer review? Yes No
- g. Have you ever voluntarily surrendered or had a DEA license refused, suspended or revoked? Yes No

2. Does your office comply with OSHA and ADA guidelines for infection control?

Yes No If "No", please explain in space provided for "Remarks".

- a. Do you autoclave or heat sterilize equipment after each patient? Yes No If "No", explain in space provided for "Remarks".
- b. Do you wear surgical gloves, mask, gown and protective eyewear for all patient care? Yes No
If "No", explain in space provided for "Remarks".

3. Are you a member of a local, state or national dental association? Yes No

If "Yes", please list name of the association: _____

4. a. Dentist procedure checklist. Indicate the percentage of time devoted to the following activities and check the techniques or procedures you perform. **Percentage must add up to 100%. Please do not list 100%**

General Dentistry.

_____ % Endodontics

Do you treat only single rooted teeth? Yes No

Do you treat multi-rooted teeth? Yes No

Do you use Sargenti paste / cement? Yes No

_____ % Pedodontics

_____ % Orthodontics

_____ % Periodontics:

Check Appropriate Procedures / Cases Treated

_____ Gingivitis _____ Slight Periodontitis _____ Moderate Periodontitis

_____ Osseous Surgery _____ Advanced Periodontitis

_____ Refractory Progressive Periodontitis

_____ % Prosthodontics:

_____ Removable _____ Fixed

_____ % Surgery:

_____ Orthognathic Surgery _____ Reducing Fractures

_____ Traumatic Surgery - please explain on the last page.

_____ Other - Please describe in space provided for "Remarks".

_____ % General Dentistry (including simple extractions, but not procedures listed above)

_____ % Other, please describe (print or type): _____

b. 1. Do you extract third molars? If yes, Yes No

(a) Erupted Yes No

(b) Impacted, soft tissue or partial bony Yes No

(c) Impacted, other than soft tissue or other than partial bony Yes No

2. Do you perform oral cancer examinations? Yes No

5. Check the following additional dental techniques or procedures you perform:

a. Prosthetic implants Yes No If "Yes", please describe in space provided for "Remarks".

b. Mini or immediate load implants Yes No If "Yes", please describe in space provided for "Remarks".

c. Temporary Anchorage Devices (TAD) or micro implants Yes No If "Yes", please describe in space provided for "Remarks".

d. Surgical implants Yes No If "Yes", complete Section VIII.

e. Treatment of Temporomandibular Joint (TMJ) disorders Yes No If "Yes", please describe in space provided for "Remarks".

6. a. Do you utilize professional independent contractors in your practice? Yes No

If "Yes", please explain your working relationship in the "Remarks" section of this application.

If "Yes", a certificate of insurance with a minimum limit of \$1,000,000 is required from the independent contractor.

b. Does the independent contractor perform procedures beyond the scope that you perform? Yes No

If "Yes", please explain in the "Remarks" section of this application.

c. How many professional independent contractors do you utilize? _____

SECTION V - PRACTICE INFORMATION (CONT'D)

7. Which of the following procedures do you perform?
 a. Botox®, Restylane®, and / or other dermal procedures (including hyaluronic acid products, collagen injections, dermabrasions, etc.) Yes No If "Yes", please provide an explanation as an attachment.
 b. Sleep Apnea Therapy Yes No If "Yes", please indicate the following: I treat only after referral from a physician. I treat without a physician referral.
8. Number of professional employees in the following categories:
 _____ Hygienists _____ Dental Assistants _____ E.F.D.A.s _____ Anesthesiologists / Anesthetists
 _____ Others, please describe: _____
 _____ Dentists (attach separate application for each)

SECTION VI - ANESTHETIC AND OTHER INFORMATION

1. Do you utilize any of the following anesthesia?
 a. Local anesthesia or inhalation sedation (N2O)..... Yes No
 b. Oral sedation..... Yes No
 c. Intravenous conscious sedation (IV) Yes No
 d. Intramuscular sedation *(IM)..... Yes No
 e. General anesthesia* (includes deep sedation) Yes No
 *If "Yes", is IM or general anesthesia administered in the hospital only? Yes No
 Do you, an employee of yours or a trained anesthetist administer the general anesthesia or intramuscular sedation? Self, Employee Anesthetist - Independent Contractor
2. Describe IV training and courses taken: _____
 a. Attach copy of certificate / license to provide I,V. sedation (required if "Yes" to question c. or d. above.)
 b. Attach a copy of your current CPR card / certificate. (required)
3. Do you consult with the patient's primary care physician on underlying health conditions; i.e., diabetes, heart, existing infections, etc.? Yes No
 If "No", please explain in space provided for "Remarks".
4. Do you obtain a complete medical history on all patients? Yes No How often is the information updated? _____
 If "No", please explain in space provided for "Remarks".
5. Do you obtain a patient "informed consent" form? Yes No If "Yes", explain on last page the procedures for which you obtain the form.
 If "No", please explain in space provided for "Remarks".

SECTION VII - PRIOR ACTS COVERAGE: COMPLETE THIS SECTION ONLY IF YOU ANSWERED "YES" TO SECTION IV, No. 5.

If you are applying for prior acts coverage, please answer the following questions.

1. History of Professional Insurance - Complete the following for the last five-year period:
 Professional Coverage - Primary and Umbrella (Excess)

Policy Term	Name of Carrier	Limit Each Claim / Agg.	Claims-Made	Retro Date

2. Do you know of any circumstances, acts, errors or omissions which could result in a professional liability claim? Yes No If "Yes", describe fully in space provided for "Remarks", and indicate if prior carriers have been notified.
3. Prior acts coverage to be effective - From: _____ (retroactive date)
4. Please indicate the limits of insurance requested for the prior acts period.
 Each Incident \$ _____ Aggregate \$ _____

**SECTION VIII - IMPLANT INFORMATION - COMPLETE IF PERFORMING SURGICAL
PLACEMENT OF IMPLANTS**

1. Describe the formal training you have received in implantology. Attach description of courses you attended, dates the courses were held and name and location of teaching entity. Include a list of continuing education courses you have attended in the past two years. _____

2. Has your training in implantology been classroom, hands-on or both? _____
3. When did you first start placing implants? _____
4. What type of implants do you place?
 - a. Endosteal Yes No
 - b. Subperiosteal Yes No
 - c. Other (please describe): _____

5. How many implants have you placed over the past 24 months and how many implant patients did you treat during the same period? _____
6. How many patients do you estimate placing implants in over the next 24 months? _____
7. Attach copies of the informed consent form and patient education material you utilize prior to placing implants.
8. What criteria do you use in selecting patients for implants? _____

NOTE TO APPLICANT: PLEASE READ CAREFULLY

You agree that signing this application does not bind The Company to provide the insurance; however, this application will be the basis of the contract should a policy be issued. You certify that reasonable inquiry has been made to obtain the answers given in the application and that this application has been completed in a true, correct and complete manner to the best of your knowledge and belief. You also certify that you are duly registered and licensed to practice your profession under the laws of all jurisdictions of which you practice.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE / SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 (VT: MAY BE COMMITTING A CRIME SUBJECTING) THE PERSON TO CRIMINAL AND (NY: SUBSTANTIAL) CIVIL PENALTIES. IN THE DISTRICT OF COLUMBIA, LOUISIANA, MAINE, TENNESSEE, VIRGINIA AND WASHINGTON, INSURANCE BENEFITS MAY ALSO BE DENIED.

Applicant's Signature

Date

Agent's Signature

Date

Agency and Code Number

Agent's Name and License Number (Florida only)