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".

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d. Has your membership in a dental association ever been revoked or suspended?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

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 **Check Appropriate Procedures / Cases Treated**
   _____ % Periodontics: _____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. Botulinum toxins, dermal fillers, and / or other dermal procedures (including hyaluronic acid products, collagen injections, dermabrasions, etc.) ☐ Yes ☐ No If "Yes", please provide a copy of the proper training course certificate of completion. Also, provide a copy of the waiver / informed consent form used with your patients.
   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 (N_2O)..... ☐ 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? _____

SECTION IX - SUPPLEMENTAL INFORMATION

CLAIM INFORMATION

1. Name of patient / claimant: _____ 2. Date of treatment to allegation _____

3. Allegation: _____

4. Date of claim / suit _____ 5. Additional defendants _____

5.a. Claim reported to prior carrier ☐ yes ☐ no

5.b. Name of insurer _____

6. Current disposition: open _____ Amount of reserve $ _____

closed _____ Amount of settlement or judgment $ _____

If no payment, was claim / suit withdrawn ☐ yes ☐ no

Please provide a narrative description of the case, including nature of treatment, your involvement, etc. _____

Remarks Section Number / Question Number	Explanation

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)