Application for Claims-Made Dental Professional Liability Insurance

ace usa

VERY IMPORTANT

1. **All dentists in the practice must complete separate applications.**
2. **A copy of your practice letterhead must accompany your application.**

The following are representative of facts known by me to be true. I agree that any coverage issued will be contingent upon the truth thereof.

Applicant's Instructions

1. Answer all questions. If a question is not applicable, state N/A.
2. If space is insufficient to answer any question fully, use a separate sheet.
3. Application **MUST** be filled out, signed and dated by applicant.
4. If answer is any question is **"NONE,"** state **"NONE."**
5. An incomplete application cannot be evaluated.
6. Please type or print in ink.

Limits Requested

☐ 1,000,000/1,000,000 ☐ New ☐ Renewal of Policy Number ____________

☐ 1,000,000/3,000,000 Requested Effective Date: ____________

☐ Other (Please specify) ______ / ______ Retroactive Date: ____________

General Information

(1) Name: ____________ (2) Social Security No.: ____________

(3) Name of Practice (Please provide name of legal entity): ____________

(4) Do you wish a separate limit of liability to apply to this entity? ☐ Yes ☐ No
(If No, limit will be shared with applicant.)

(5) Mailing Address: ____________
STREET CITY COUNTY STATE ZIP

(6) Office Address: ____________
STREET CITY COUNTY STATE ZIP

(7) Phone: (   ) ____________ (8) Date of Birth: / / (9) Years in Practice: ______

(10) Address of all locations where you practice: ____________

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(11) How many hours per week do you practice (Include lab work, patient visitation and consultation): ______

(12) Are you currently licensed to practice dentistry in your state(s) of practice? ☐ Yes ☐ No

(13) Narcotics (DEA) License No.: ____________ (14) Expiration Date: / /

(15) Do you possess another professional degree which enables you to practice in another field, such as law or medicine?
☐ Yes ☐ No If Yes, please describe: ______________________________

Do you practice in this field? ☐ Yes ☐ No Are you insured for this exposure? ☐ Yes ☐ No

(16) Character of Practice: (check all that apply)

☐ General Dentistry
☐ Dental Public Health
☐ Pediatric Dentistry
☐ Faculty - Intramural
☐ General Dentistry limited to (e.g., TMJ, Implants): ______________
☐ Periodontics
☐ Oral Surgery
☐ Faculty - Non-Intramural
☐ Endodontics
☐ Prosthodontics
☐ Oral Pathology
☐ Orthodontics

(17) Under which of the following do you provide professional services?

☐ Unincorporated individual
☐ Independent Contractor
☐ Other (describe): ______________________________
☐ Multi-Dentist Corporation
☐ Professional Association Corporation
☐ Partnership

(18) Are you an employee of, or under contract to, a government body, educational facility, or professional sports organization? ☐ Yes ☐ No If Yes, please explain and/or include a copy of contract.

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(19) Are you engaged in any written agreements and/or contracts that contain a hold harmless clause which may involve your dental practice? ☐ Yes ☐ No
If Yes, include a copy of the contract if you wish coverage to be considered.

(20) Please indicate any continuing education programs you have attended in the last five years. Include date and length of program on a separate sheet of paper.

(21) Give a brief description of your dental employment history, including locations and dates. ______________

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(22) Please indicate which of the following, if any, have occurred in your practice.

A. Have you had a change in the status of your:
Dental License ☐ Yes ☐ No Hospital Privileges ☐ Yes ☐ No
Narcotics License ☐ Yes ☐ No
Provide details of any Yes answer on a separate sheet of paper.

B. Has any governmental agency, including State Licensing Board, investigated you, suspended, revoked, or taken any other action against either your narcotics license or license to practice dentistry? ☐ Yes ☐ No
If Yes, provide a copy of the Board Transcript including resolution.

C. Have you been convicted of any criminal charges within the past five years? ☐ Yes ☐ No If Yes, provide details from investigating agency.

D. Have you had any personal health problems (including alcoholism, drug addiction or mental illness) within the past five years? ☐ Yes ☐ No If Yes, provide a letter from treating physician with complete details.

E. Have any Medicare/Medicaid fraud charges been filed against you? ☐ Yes ☐ No
If Yes, provide details of allegation and resolution from investigating agency.

Employee/Contractor Information

(23) Complete the chart below, indicate the number of persons in each category:

	Part Time		Full Time		Part Time		Full Time
Dentists:	____	/	____	Dental Assistants:	____	/	____
MDs:	____	/	____	Lab Technicians:	____	/	____
Nurse Anesthetists:	____	/	____	Receptionists:	____	/	____
Nurses:	____	/	____	Other:	____	/	____

(24) On a separate sheet of paper, please describe all independent contractors by name, position, and number of hours worked per week. Also attach a Certificate of Insurance from their Professional Liability carrier.

(25) Other than employees and independent contractors, do you share office space or staff with any other dentist?
☐ Yes ☐ No If Yes, please describe on a separate sheet of paper.

Insurance History

(26) Are you now, or have you ever, practiced without Professional Liability Insurance? ☐ Yes ☐ No
If Yes, please provide dates and reason: ______________________________

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(27) Reserved for future use.

(28) Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
If Yes, please complete a Supplemental Claim Information form.

(29) Are you currently aware of any situation that could lead to a malpractice suit against you? ☐ Yes ☐ No
If Yes, please complete a Supplemental Claim Information form.

(30) To help ascertain correct coverage, it is important that the following chart be completed in detail.

	Professional Liability Insurer	Limits of Liability: Per Claim / Aggregate	Policy Period: Month / Day / Year		Type of Policy: Claims-Made or Occurrence
Current Year*		/	From:	To:	
1st Prior Yr.		/	From:	To:	
2nd Prior Yr.		/	From:	To:	
3rd Prior Yr.		/	From:	To:	
4th Prior Yr.		/	From:	To:	

* My current Professional Liability Insurance Premium is: $ ____________ .

(31) If your expiring policy is on a claims-made basis, an Extended Reporting Period is generally available as an option of your expiring claims-made policy.

A. Are you exercising this option? ☐ Yes ☐ No

B. If No, do you want ACE to afford coverage for Prior Acts (claims for incidents which may have occurred but, as yet, no indication thereof has been made to you)? ☐ Yes ☐ No

C. Have there been any changes in your specialty, location or legal entities within the past 5 years?
☐ Yes ☐ No If Yes, please explain: ______________________________

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Anesthesia Information

- Please be sure to read and answer all parts very carefully.
- If you answer "Yes" to question 33 or 34, you must complete the Anesthesia Supplement to this application.

(32) Is your practice limited to the use of local anesthesia and/or oral medication, including Nitrous Oxide euphoria?
☐ Yes ☐ No

(33) Are you treating patients who are under conscious sedation? (For purposes of this application, the use of Nitrous Oxide solely as an analgesic is not considered conscious sedation.) ☐ Yes ☐ No
If Yes, please complete the Anesthesia Supplement.

(34) Are you treating patients who are under general anesthesia (deep sedation)? ☐ Yes ☐ No
If Yes, please complete the Anesthesia Supplement.

(35) Please briefly describe the use of anesthetics and the use of any type of analgesia in your practice.

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(36) Are you equipped and trained to use the following emergency procedures?

A. Positive pressure endotrachial respiratory assistance. ☐ Yes ☐ No

B. Intravenous emergency medications. ☐ Yes ☐ No

C. External cardiac massage. ☐ Yes ☐ No

Other, please specify: ____

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I hereby request that my application for professional liability claims-made coverage be submitted to ACE Insurance Companies. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to the ACE Insurance Companies any and all information which may relate to my insurability under the applied for professional liability claims-made coverage.

"This insurance is void in any case of fraud, material misrepresentation or material omission made by you or with your knowledge in obtaining this insurance or pursuing a claim under the policy."

I hereby authorize ACE 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"** basis and acknowledge that this coverage will only respond to claims which arise from dental incidents taking place on or after the retroactive date of the policy and which are first made against me and reported to ACE in writing during the policy period or any applicable reporting period.

I understand that **"CLAIMS-MADE"** coverage gives me the right, subject to the terms of the policy, to purchase a Supplemental Extended Reporting Period Endorsement in the event of policy termination. Such endorsement is required to provide coverage for claims reported to ACE after the termination date, but which arise from dental incidents occurring after the Retroactive date and prior to the termination date of the policy to which this endorsement attaches.

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. In New York, any person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

______________________________ APPLICANT'S SIGNATURE

______________ DATE

ACE USA
Specialty Insurance

Dental Professional Liability Insurance
Anesthesia Supplemental Application

This supplement is to be completed *only* if you answered **Yes** to questions 33 or 34 on the general application.

For the purposes of this questionnaire, the following definitions are provided:

Anesthesia:	means any form of inhalation, intravenous, oral, or intramuscular anesthesia or analgesia and/or combination thereof.
General Anesthesia:	means the elimination of all sensations, accompanied by a state of unconsciousness.
Conscious Sedation:	means the calming of a nervous, apprehensive individual by use of systemic drugs, without inducing loss of consciousness.

1. Type of anesthesia/analgesic used for treating patients under General Anesthesia (please specify when used in combination with other anesthetic or analgesic agents):

   a. ☐ Inhalation:__________
      ☐ Nitrous Oxide (if used in combination with other drugs):__________
      ☐ Other:__________

   b. Intravenous:__________

   c. Intramuscular (including submucosal):__________

   d. Oral:__________

   e. Combination:__________

2. Where are General Anesthesia procedures performed?
   Dental Office:________ % Hospital:________ %

3. Type of anesthesia/analgesic used when treating patients under Conscious Sedation (please specify when used in combination with other anesthesia or analgesic agents):

   a. ☐ Inhalation:__________
      ☐ Nitrous Oxide (if used in combination with other drugs):__________
      ☐ Other:__________

   b. Intravenous:__________

   c. Intramuscular (including submucosal):__________

   d. Oral:__________

   e. Combination:__________

4. Where are Conscious Sedation procedures performed?
   Dental Office:________ % Hospital:________ %
   Number of procedures per month:______

5. Please indicate the number of years you have been using Conscious Sedation and/or General Anesthesia *in your office.*

   Conscious Sedation: ____ General Anesthesia:____

6. Please indicate if you have had the following training, and if so, the date and period of time spent in training:

   a. Hospital training in the use of General Anesthesia: ______________________________

   b. University training in the use of General Anesthesia: ______________________________

   c. Hospital training in the use of Conscious Sedation: ______________________________

   d. University training in the use of Conscious Sedation: ______________________________

   e. Other types of training (e.g., continuing education programs): ______________________________

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7. Are you certified by, or a member of, any of the following organizations which require training in General Anesthesia?

   ☐ AAOMS ☐ ACOMS ☐ Fellow, ADSA ☐ Member, ADSA

   ☐ Other (specify): ______________________________

8. Do you utilize the services of dental anesthesiologists, RNA's, or the like? ☐ Yes ☐ No

   If Yes, describe in detail: ______________________________

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____
SIGNATURE

ACE USA
Specialty Insurance

Dental Professional Liability Supplemental Claim Information

Applicant's Instructions:

- ***Complete one form for each claim or suit.***
- ***If space is insufficient to answer any questions fully, use reverse side of this page or attach a separate sheet.***
- ***Answer all questions completely. Please type or print.***

1. NAME OF APPLICANT

2. NAME OF PATIENT/CLAIMANT | AGE | SEX

3. DATE(S) OF TREATMENT TO ALLEGATION

LOCATION

4. ALLEGATION

5. DATE OF CLAIM/SUIT | NAME OF INSURER

6. ADDITIONAL DEFENDANTS

7. CURRENT DISPOSITION

☐ Open Amount of reserve: ____________________

☐ Closed Amount of settlement or judgment: ____________________

Amount paid on applicant's behalf: ____________________

If no payment, was claim/suit withdrawn? ☐ Yes ☐ No

8. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE CASE, INCLUDING THE NATURE OF TREATMENT, YOUR INVOLVEMENT, ETC.

I understand that the information submitted herein becomes part of my Professional Liability Application as submitted.

____________________ DATE

____________________ APPLICANT'S SIGNATURE