PSIC | Professional Solutions INSURANCE COMPANY

Dental Professional Liability Application

A. AGENCY INFORMATION

Agency Name:_____ Agent Contact: _____

Address:_____
Street City State Zip

Office Phone:_____ Email Address:_____
Your email address will never be sold. It will be used to send you important messages.

B. APPLICANT INFORMATION

Name _____
First Middle Last

☐ Female ☐ Male Social Security No. (last 4 digits)_____ Date of Birth:_____
MO/DAY/YR

Office Phone:_____Office Fax:_____

Email Address:_____ Cell Phone: _____
Your email address will never be sold. It will be used to send you important messages.

Primary Office Address:

_____ _____ % of Practice
Street City State Zip County

Additional Practice Location(s):

_____ _____ % of Practice
Street City State Zip County

_____ _____ % of Practice
Street City State Zip County **(All locations must total 100%)**

Mailing/Billing Address: ☐ Primary Office Address
☐ Other:_____
Street City State Zip

IF MORE ROOM IS NEEDED FOR PRACTICE LOCATIONS, PLEASE USE A SEPARATE PIECE OF PAPER.

C. COVERAGE INFORMATION

1. Effective date desired:_____ (policy issued annually)
MO/DAY/YR

2. Select requested coverage:

☐ CLAIMS-MADE COVERAGE ***with*** PRIOR ACTS
Desired Retroactive Date:_____
MO/DAY/YR

The retroactive date is the date first continuously insured under a Claims-Made policy. Please contact your agent should you have any questions pertaining to Claims-Made coverage or the need for Prior Acts coverage.

☐ OCCURRENCE

I realize that if I switch from a Claims-Made to an Occurrence policy, my failure to purchase an extended reporting endorsement from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's claims-made policy. I understand the policy I am purchasing will not provide prior acts coverage.

☐ CLAIMS-MADE COVERAGE ***without*** PRIOR ACTS
(select one below)

☐ Expiring Occurrence Coverage

☐ An extended reporting endorsement **has** been purchased

☐ An extended reporting endorsement **has not** been purchased

I realize that my failure to purchase an extended reporting endorsement from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's claims-made policy. I understand the policy I am purchasing will not provide prior acts coverage.

C. COVERAGE INFORMATION (continued)

3. Please indicate the limits of liability requested for coverage or a quote: *(Not all limits may be available in all states. Additional limit options available in VA.)*

☐ $100,000/$300,000 ☐ $250,000/$750,000 ☐ $1,100,000/$3,000,000
☐ $200,000/$600,000 ☐ $500,000/$1,000,000 ☐ $2,000,000/$4,000,000

4. Please provide information on each professional liability insurer you have had for the last 10 years. *Please provide this information in chronological order:*

Dates	Insurer	Coverage Type	Tail Coverage Purchased?	Any Claims?
		☐ Occurrence ☐ Claims-Made	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Occurrence ☐ Claims-Made	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Occurrence ☐ Claims-Made	☐ Yes ☐ No	☐ Yes ☐ No

PLEASE ATTACH A COPY OF YOUR DECLARATIONS PAGE FROM YOUR CURRENT OR PREVIOUS PRIMARY INSURER.

5. Are you now practicing, or have you ever practiced without professional liability insurance? ..... ☐ Yes ☐ No
6. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? *(Missouri residents, skip this question.)* ..... ☐ Yes ☐ No
7. Number of hours per week you practice dentistry: _____
8. Will you perform activities that will be covered by another professional liability policy? ..... ☐ Yes ☐ No
   If yes, please attach a copy of your declarations page, a description of these activities and the practice name and location.
9. Will you be participating in a state-operated patient's compensation fund? *(Indiana residents only.)* ..... ☐ Yes ☐ No

D. EDUCATION

1. School of Graduation: _____
   Name State Country
   Degree (DMD, DDS, BDS): _____ Graduation Date: _____
   MO/DAY/YR
2. Clinical Based Training, Residency or Fellowship (facility, state):
   _____
   Name State Country
   Specialty Type: _____ Date Completed: _____
   MO/DAY/YR
3. Additional Training:
   _____
   Name State Country
   Specialty Type: _____ Date Completed: _____
4. Have you participated in any continuing dental education within the last two years? ..... ☐ Yes ☐ No
   If yes, how many credit hours? _____
5. Have you completed any risk management/loss prevention courses in the past 12 months? ..... ☐ Yes ☐ No
   If yes, please attach a copy of any Certificates of Completion.

E. PRACTICE LOCATION AND LICENSE INFORMATION

1. Please list all states in which you currently hold or have held a license:

   State: _____ License No. : _____ Activities in this state _____%

   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending

   State: _____ License No. : _____ Activities in this state _____%

   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending

   State: _____ License No. : _____ Activities in this state _____%

   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending **(All activities must total 100%)**

2. DEA License? ..... ☐ Yes ☐ No
3. Please indicate the number of years at current practice address: _____
4. Prior practice addresses for past 10 years (name of practice, location, dates worked):

Name of Practice	City/State	Dates Worked (MO/YR to MO/YR)

F. PRACTICE ORGANIZATION INFORMATION

1. Employment Status: ☐ Employee ☐ Independent Contractor ☐ Solo Unincorporated/Sole Proprietor
   ☐ Shareholder/Partner ☐ Other: _____

   If you are an Employee or Independent Contractor,

   Name of Employer/Dental Office: _____

   PSIC Policy Number of Entity/Group: _____

2. Entity Type: ☐ Solo Incorporated – No employee or contracted dentist ☐ Partnership/LLC
   ☐ Multi-Shareholder Corporation ☐ Dental Service Organization
   ☐ Other: _____

   If you are Solo Incorporated, Partnership or Corporation, please provide

   name of legal entity: _____

   Is this entity insured with PSIC? ..... ☐ Yes ☐ No

   If yes, what is the policy number: _____

   If no, do you desire coverage for this entity? ..... ☐ Yes ☐ No

   If yes, please complete the Entity Application.

3. Do you own or operate a dental laboratory? ..... ☐ Yes ☐ No

   If yes, please estimate the percentage of your dental laboratory work applicable to patients other than your own: ___ %

4. Do you operate or work for a mobile dental practice? ..... ☐ Yes ☐ No

   If yes, complete the Mobile Dentistry Supplement Form.

5. What percentage of your revenue is from each of the following sources:

   ☐ Indemnity Private Insurance:_____% ☐ Government Programs (Medicare/Medicaid):_____%

   ☐ Other: (please explain):_____%

G. PRACTICE ACTIVITIES

1. Please indicate your specialty:

☐ Dental Anesthesiologist ☐ Oral & Maxillofacial Radiology ☐ Pediatric Dentistry
☐ Endodontics ☐ Oral & Maxillofacial Surgery ☐ Periodontics
☐ General Dentistry ☐ Orthodontics ☐ Prosthodontics
☐ Oral & Maxillofacial Pathology ☐ Other (please explain):_____

2. Please indicate which of the following procedures you perform and your level of training:

	Do Not Perform	Residency/ Fellowship	16+ CE's	Dental School	Type of Informed Consent Obtained? Written, Oral or None
Sinus Lifts	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)
Dental Implants	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)
Sleep Apnea Therapy	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)
Partially Impacted Third Molar Extractions	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)
Fully Impacted Third Molar Extractions	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)
Oral and Maxillofacial Surgery	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)
Botox and/or Cosmetic Fillers	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)
Please provide certificates of completion confirming 16 hours of PACE-approved course work.					
Sargenti Root Canal Therapy (N2 paste)	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)
Facial Invasive (Face Lift, Rhinoplasty, Cleft lip/palate etc.)	☐	☐	☐	☐	☐ (W) ☐ (O) ☐ (N)

3. If you perform sinus lifts, please provide the number of sinus lift procedures performed annually: _____
Percent of practice _____% What percent are direct _____%. What percent are indirect? _____%.
4. If you perform dental implants, please estimate the number performed annually:_____
What percentage of those dental implants are restoring existing implants _____%
What percentage are placing new implants _____% What percentage are mini implants _____%
(Should total 100%)
5. If you perform sleep apnea therapy, do you treat only after referral from a physician? ..... ☐ Yes ☐ No
6. Do you use nitrous oxide in conjunction with other types of sedation noted below for patient procedures?..... ☐ Yes ☐ No
If yes, the purpose is: ☐ Anxiolysis/minimal sedation ☐ Moderate sedation
7. Please mark below all types of sedation and/or anesthesia used in your practice:

☐ Local Anesthesia ☐ Single Dose Oral Sedation (anxiolysis/minimal)
☐ Nitrous Oxide ☐ Multi-Dose Oral Sedation (moderate)
☐ IV/IM – Moderate Sedation ☐ General Anesthesia - Deep Sedation
☐ Other (please explain): _____
☐ None of the above

8. Please indicate who administers the sedation and/or anesthesia noted above:

☐ I do ☐ Nurse Anesthetist/CRNA ☐ Oral Surgeon
☐ Dental Anesthesiologist ☐ RN/LPN ☐ MD/DO Anesthesiologist
☐ Other (please explain): _____

9. Where is the sedation and/or anesthesia noted above performed?

☐ Dental Office ☐ Hospital ☐ Licensed Surgical Center (licensed by what agency?) _____
☐ Other (please explain): _____

10. If you treat patients under general anesthesia/deep sedation, please advise how often?_____
What percentage of this of your total practice? _____%
11. Please indicate the type of consent obtained for the sedation and/or anesthesia noted above:

☐ Written ☐ Oral ☐ None

12. How often do you update health histories?

☐ Every 3 months ☐ Every 6 months ☐ Every 12 months
☐ Other (please explain): _____

H. PROFESSIONAL INFORMATION

1. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
   If yes, what percentage of your practice is devoted to these activities? _____ %
   If yes, where are professional services rendered? _____
2. Do you review treatment or provide professional services to patients in a nursing home or skilled care facility? ☐ Yes ☐ No
   If yes, what percentage of your practice time is dedicated to these services? _____ %
   If yes, where are professional services rendered? _____
3. Do you participate in any dental research, clinical trials or off-label use of drugs or devices?. ☐ Yes ☐ No
   If yes, please attach copies of any protocols and informed consent documents.
4. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than minor traffic offenses? ☐ Yes ☐ No
5. Have you ever had your dental license, hospital privileges, DEA license, or reimbursement privileges refused, denied, revoked, suspended, investigated, restricted, subject to reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No
6. Have any complaints or actions been brought against you alleging sexual misconduct? ☐ Yes ☐ No
7. Have you incurred or become aware of having a condition that impairs your ability to practice dentistry to any degree? (i.e., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics, or other controlled substances, etc.) ☐ Yes ☐ No
8. Do you use a collection agency which has the authority to file collection suits without your knowledge? ☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A SEPARATE PIECE OF PAPER.

I. LOSS INFORMATION

1. Within the last 10 years, have you been involved, directly or indirectly, in a **claim** or suit arising out of the rendering or failing to render professional services?* ☐ Yes ☐ No
   If yes, please indicate the number: _____
2. Within the last 10 years, have you become aware of any **potential claims** arising out of the rendering or failing to render professional services? ☐ Yes ☐ No
3. If you answered yes to either of the above questions, have any and all **claims** and **potential claims** been reported to your current or prior insurer? ☐ Yes ☐ No
   If no, please explain: _____

For the purposes of this section, the word **claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you or any professional corporation or partnership.*

*For the purpose of this section, the word **potential claim** is defined as any incident or circumstance indicating the possibility of a legal action against you or any professional corporation/partnership. (This may include, but is not limited to: a letter from an attorney or a patient requesting medical records or expressing dissatisfaction regarding your dental treatment, a patient's or family member's dissatisfaction with the outcome of a procedure, treatment, or diagnosis, or any other situation that might reasonably lead to a claim or suit.)*

FOR EACH PENDING SUIT, CLOSED CLAIM AND POTENTIAL CLAIM, PLEASE COMPLETE AND ATTACH A CLAIM INFORMATION FORM.

J. APPLICATION CHECKLIST

Please remember to attach a copy of the following with the application:

- Your most recent declarations page.
- If claims are noted on the application, include a minimum of 10-years' loss run from your current and prior insurance companies, and complete the Claim Information form.
- Copy of dental licenses.

PLEASE COMPLETELY FILL OUT ALL AREAS ON THE APPLICATION. IF ANY AREAS DO NOT APPLY, PLEASE STATE, "N/A."

K. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS INSURANCE COMPANY.

THE ABOVE STATEMENTS ARE, TO THE BEST OF MY KNOWLEDGE, THE TRUTH, AND I HAVE NOT KNOWINGLY SUPPRESSED, WITHHELD OR MISSTATED ANY MATERIAL FACT IN COMPLETING THIS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE.

The undersigned represents and acknowledges that all information provided including the application, its supplements, attachments and answers to any questions our underwriter asks will be relied upon by PSIC in determining whether to insure and at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by Professional Solutions Insurance Company (PSIC) and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that 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 PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of dentistry within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state dental license, DEA license or any hospital privileges;
- Any mental or physical condition, that materially impairs my ability to practice dentistry, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to PSIC during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

For residents of all states except Colorado, Maryland, New York, New Jersey, Oregon, Tennessee, Virginia and Washington: 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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Colorado residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Maryland residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New York residents: 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 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. (11 NYCRR 86.4(a)) {parallel citation Regulation 95}

New Jersey residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oregon residents: 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 or knowingly helps with intent to defraud, may be subject to prosecution for insurance fraud.

Tennessee, Virginia and Washington residents: 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.

Malpractice Insurance is underwritten by Professional Solutions Insurance Company.

Signature of Applicant

Date

Signature of Soliciting Agent (Please Print Full Name)

Agency Name

PSIC | Professional Solutions INSURANCE COMPANY

Mail to:
14001 University Avenue
Clive, Iowa 50325-8258

Questions:
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Fax: 800-600-8170

Email: dentalsubmissions@psicinsurance.com