Dental Application

for surplus lines coverage

- **If a question does not apply to you, write "N/A". Do not leave any questions unanswered.**
- **Include a copy of the following:** ⎫ **Current Declarations Page** ⎫ **Loss Runs**
  ⎫ **CV** *(if information is not already provided in application)*

1. PERSONAL DATA

Last Name _____ **First Name** _____ **M.I.** _____ **Title** _____

Date of Birth: _____ Social Security No: _____ Gender: ☐ M ☐ F

Clinic Name/Employer: _____

Office Address: _____ Office Phone: _____

City/State/Zip: _____ County: _____

Number of years at current office location: _____ % of practice at this location: _____

List all other office locations where you will practice your profession:

Address: _____ City/State/County: _____

Address: _____ City/State/County: _____

Residence Address: _____ City/State/County: _____

Office Phone: _____ Email address: _____

2. INSURANCE COVERAGE REQUESTED

Requested Effective Date: _____ Prior Acts Date (Retroactive Date): _____

Requested limits of liability (per claim/aggregate): ☐ $1,000,000/$3,000,000 ☐ Other: $_____

Deductible: (per claim/aggregate): ☐ $5,000 per claim ☐ Other: $_____ ☐ None

3. PRACTICE INFORMATION

A. States in which you hold a license to practice dentistry:
Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

			Active	Inactive	Temporary	Pending
1. State_____	License # _____		☐	☐	☐	☐
2. State_____	License # _____		☐	☐	☐	☐
3. DEA License?	☐ Yes	☐ No				

Are you Board Certified? ☐ Yes ☐ No Date Certified: _____ Expiration Date: _____

4. RATING INFORMATION

A. Please indicate the estimated average weekly numbers, under each of the following categories, for which you require coverage: (If none, please enter '0' in the space provided.)

Patients Per Week _____ Hours Per Week _____ Unscheduled New Walk-In Patients Per Week _____

B. Please check your present specialty:

☐ General Dentist
☐ Orthodontist
☐ PediatricDentist
☐ Endodontist
☐ Prosthodontist
☐ Oral Pathologist
☐ Dental Anesthesiologist
☐ Pain Management (Please explain) _____
☐ Oral & Maxillofacial Surgeon
☐ Dual Degree
☐ Periodontist
☐ Other (Please explain) _____

C. Please check procedures you will perform in your practice:

☐ Sinus Lifts ☐ Nerve Grafts ☐ Face Lifts ☐ Orthognathic Surgery
☐ Rhinoplasty ☐ Skin Peels ☐ Cleft Lip and Palate Surgery ☐ Trigger Point Injections
☐ Management of Malignant Lesions ☐ Obesity/Weight Control Treatment
☐ Implant Prosthesis/Supported Prosthesis ☐ Placement of Mini Implants for Orthodontics/Prosthesis
☐ Botox, Dermal Fillers (i.e. Injections) ☐ Cosmetic Full Mouth Rehabilitation
☐ Spa Services Please explain: _____
☐ TMJ Surgery
☐ Arthroscopy ☐ Implant ☐ Reconstruction
☐ Orthodontic Full Mouth Banding Year you began this procedure (YYYY): _____
☐ Sargenti Root Canal Method Utilizing N2 or Similar Paste
☐ Surgical Placement of Implant Fixtures Year you began this procedure (YYYY): _____
☐ Alternative (Holistic) Dentistry/Medicine Please explain : _____
☐ Sleep Apnea Therapy Do you treat only after a physician referral? ☐ Yes ☐ No
☐ Third Molar Extractions (CPT/CDT Codes)
☐ Erupted (D7110, D7120, D7210) Year you began this procedure (YYYY): _____
☐ Partially Impacted (D7220, D7230) Year you began this procedure (YYYY): _____
☐ Fully Impacted (D7240, D7241, D7250) Year you began this procedure (YYYY): _____
☐ Palatal Inserts Do you treat only after a physician referral? ☐ Yes ☐ No

D. Indicate the percentage of your practice devoted to the following procedures:
(Total does not have to equal 100%)

___ % Denture Procedures ☐ Same Day or Economy ☐ Replacement ☐ Relines
___ % Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)
___ % Elective Facial Cosmetic Surgical Procedures (including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)
___ % Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)
___ % Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

E. Please indicate which procedures you perform and whether you obtain informed consent and training for each of the procedures selected.

	Informed Consent Type	Training
☐ Orthodontic Full Mouth Banding	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ Surgical Placement of Implant Fixtures	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ Partially Impacted Third Molar Extractions	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ Fully Impacted Third Molar Extractions	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ Nitrous Oxide Analgesia	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ Conscious Sedation	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ General Anesthesia/Unconscious Sedation	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ Facial Surgery	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ Botox, Dermal Fillers (i.e. Injections)	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None
☐ Other (Please explain)	☐ Written ☐ Oral ☐ None	☐ CE ☐ Post Grad ☐ None

_____

F. Have you discontinued any procedure listed in C. or D. above? ☐ Yes ☐ No
Which procedures? _____ When? (MM/DD/YYYY) _____

G. Have there been any changes in your specialty, classification or practice activity within the last 5 years ☐ Yes ☐ No
If "Yes", explain: _____

H. Does your current practice involve the treatment of nursing home residents? ☐ Yes ☐ No
If "Yes", what percentage of your practice involves treatment of nursing home residents? ___ %

I. Does your current practice involve the treatment of prison inmates? ☐ Yes ☐ No
If "Yes", what percentage of your practice involves treatment of prison inmates: ___ %

J. Do you have faculty appointment? ☐ Yes ☐ No
If "Yes", provide name of insurance carrier for the educational program: _____

K. Do you have any medical related duties or practice activities that are insured elsewhere or for which you do not desire coverage? ☐ Yes ☐ No
If "Yes", provide name of insurance carrier _____

5. PRACTICE INFORMATION

Please check boxes that best describe your practice affiliation(s).

A. Employment Status:
☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other
Date Joined/Formed (MM/DD/YYYY) _____

B. Entity / Organization Type: (You must check at least one box)

☐Solo Unincorporated/Sole Proprietor ☐ Solo Incorporated
☐Multi-Shareholder Corporation, Partnership, Limited Liability Company
☐ Nursing Home Based Practice ☐ State Licensed Dental Surgery Center
☐ Dental School – Faculty ☐ Dental Students/Residents
☐Clinic Receives Governmental Immunity ☐ Mobile or Portable Dental Practice
☐ Dental School – Faculty ☐ Dental Students/Residents
☐Clinical supervision of students ☐ Other (Please explain): _____
Hours per week _____ _____

C. Name all of your affiliated professional corporations or associations (including DBA's and Individual Dentists):

_____

D. Do you desire coverage for this entity ☐ Yes ☐ No

If yes, please select the type of entity coverage desired:

- ☐ **Shared Limit –** Your individual policy limits will be shared with your **Solo Corporation.** This option is **only** available if you are Solo Incorporated and you have no employed or contracted Dentists.
- ☐ **Separate Limit –** Available for all Entity/Organization Types.

6. ROSTER OF STAFFING INFORMATION

Please identify all owners, employed and contracted individuals within your organization and provide information concerning each member in each category listed below. (use separate sheet for additional names)

	1.Last name first, then first name and middle initial (i.e. Smith, John G.)	2. Degree	3. Specialty #1-18 (Refer to Key Below)	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Individual Status A, B, C (Refer to Key Below)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Specialty: (column 3)

1. General Dentist
2. Oral and Maxillofacial Surgeon
3. Orthodontist
4. Pediatric Dentist
5. Periodontist
6. Prosthodontist
7. Endodontist
8. Dental Anesthesiologist
9. Pain Management
10. Dental Assistant
11. Dental Hygienist
12. Dental Lab Technician
13. Nurse Anesthetist / CRNA
14. RN / LPN
15. X-Ray Technician
16. Other

Individual Status: (column 5)

A. Requesting Individual coverage.
B. Applying for coverage elsewhere or covered elsewhere.
C. Shared Limit Coverage – Including Allied Health Care Professionals.

*** Note: Include all applicant(s), all healthcare provider(s) and non-healthcare owner(s).**

If Entity coverage is provided, it will include Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds as defined by the Shared Limit Additional Insured Endorsement.

7. ANESTHESIA INFORMATION

A. As defined below, please "X" if you, an employee or independent contractor treats patients under:

☐ *Conscious Sedation Utilizing CPT/CDT Code D09241 and D09242 –* (excluding nitrous oxide) 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 command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.
☒ IM/IV ☐ Oral

☐ *General Anesthesia Utilizing CPT/CDT Code D09220-* (to include deep sedation) 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 purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.
If Conscious Sedation or General Anesthesia were checked, please complete the Anesthesia Supplement.

B. ☒ Please "X" here if this section *does not* apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar nonscheduled drug) or nitrous oxide only.

8. INSURANCE HISTORY

1. **Current Carrier: _____** ☐ Claims-Made ☐ Occurrence

   Effective Date: _____ Expiration Date: _____ Prior Acts Date: _____

   Limits of Liability:_____ Per Claim/ _____ Aggregate

   ☐ Deductible ☐ SIR $: _____ Per Claim/ _____ Aggregate

   Current Annual Premium: _____

   1st prior carrier name: _____ ☐ Claims-Made ☐ Occurrence

   Effective Date: _____ Expiration Date: _____ Prior Acts Date: _____

   Limits of Liability: _____ Per Claim/ _____ Aggregate

   ☐ Deductible ☐ SIR $: _____ Per Claim/ _____ Aggregate

   2nd prior carrier name: _____ ☐ Claims-Made ☐ Occurrence

   Effective Date: _____ Expiration Date: _____ Prior Acts Date: _____

   Limits of Liability: _____ Per Claim/ _____ Aggregate

   ☐ Deductible ☐ SIR $: _____ Per Claim/ _____ Aggregate

2. If you are currently insured on a claims-made policy, are you obtaining Extended Reporting Period (tail) Coverage from your current insurance carrier? ☐ Yes ☐ No ☐ N/A *(have occurrence coverage now)*

   Note: To prevent possible gaps in your claims-made coverage, either Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from Hudson Specialty Insurance Company must be purchased. ***Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.***

9. UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

1.	Are you being investigated or have you been convicted of a misdemeanor (other than traffic related) or felony or is any charge pending?	☐ Yes ☐ No
2.	Have you been admitted or sought treatment from any mental health or chemical/substance abuse program?	☐ Yes ☐ No
3.	Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis?	☐ Yes ☐ No
4.	Have your privileges been denied, restricted, suspended, revoked or put on probation by any health dental facility?	☐ Yes ☐ No
5.	Have you ever resigned from a dental facility while under investigation to avoid possible disciplinary action?	☐ Yes ☐ No
6.	Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or healthcare facility at which you practice(d)?	☐ Yes ☐ No
7.	Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	☐ Yes ☐ No
8.	Have you provided any care that resulted in a formal incident report or investigation by any dental facility?	☐ Yes ☐ No
9.	Have Medicare or Medicaid authorities ever investigated or brought charges against you?	☐ Yes ☐ No
10.	Have you provided any professional services without professional liability insurance?	☐ Yes ☐ No
11.	Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	☐ Yes ☐ No
12.	Have you ever treated any patients by means of unconventional therapeutics, or have you utilized non-FDA approved experimental drugs other than through Institutional Review Board (IRB) approved research programs?	☐ Yes ☐ No
13.	Have you had or do you currently have any physical or mental condition, illness or defect?	☐ Yes ☐ No

10. CLAIMS INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

Within the past 10 years:

1.	Have you been involved in a malpractice claim, lawsuit, incident or occurrence in the last 10 years? If "Yes", how many?	☐ Yes ☐ No
2.	Are you aware of any circumstances that may result in malpractice claim or suit being made or being brought against you?	☐ Yes ☐ No
3.	Are you aware of any outstanding incidents, claim, or suits (even if you believe the outstanding claim or suit would be without merit) that have <u>not</u> been reported to your current or prior professional liability career?	☐ Yes ☐ No
4.	Have you been contacted by a plaintiff's attorney or required to produce medical records or statements regarding any case you have been involved with, and you have not been specifically named in the suit or claim?	☐ Yes ☐ No

COMMENTS

_____
_____
_____
_____
_____
_____
_____
_____

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application shall be the basis of the contract should a policy be issued. I agree to notify the Company of any change in my practice of medicine within (30) days of its occurrence, including but not limited to the following:

A. A change in specialty or medical procedures performed;
B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
C. Investigation, restriction, suspension or surrender of any state medical, DEA license or hospital privileges;
D. Any physical or mental condition, illness or defect, including treatment for alcohol or substance abuse not previously disclosed to the Company in writing.
E. Conviction, plea or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses.

This application is for insurance to be placed on a surplus lines basis with Hudson Specialty Insurance Company

Applicant's Signature	Print Name	Date

NOTICE

To All Prospective Insureds: 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds In:

Notice to Colorado Applicants: 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 claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia and Louisiana Applicants: "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."

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Oklahoma Applicants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Notice to Kansas Applicants: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Notice to Maine, Tennessee, Virginia and Washington Applications: 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 and/or denial of insurance benefits.

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

Notice to New Hampshire Applicants: Any person who, with a purpose to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

Notice to New York Applicants: 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 $5,000 and the stated value of the claim for each such violation.

Notice to New York Applicants (Fire insurance applications): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

Notice to New York Applicants (Automobile): Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the value of the subject motor vehicle or stated claim for each violation."

Notice to Pennsylvania Applicants: 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 purposes 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.

Notice to Pennsylvania Applicants (Automobile): Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information, shall, upon conviction, be subject to imprisonment for up to seven (7) years and the payment of a fine of up to $15,000.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

_____ _____

Signature **Date**

_____

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

Supplement Claim Information Form

(make copies of this page as needed)

1. Name of patient: _____ Age: _____ ☐ Male ☐ Female
2. Describe the allegation made by claimant: _____

_____

_____

_____

3. Date claim was made or filed: _____
4. Date of alleged incident: _____
5. Insurance company: _____
6. Additional defendants: _____
7. Disposition of claim: ☐ Open ☐ Closed

If open: Claimant's settlement demand: $ _____

Defendant's offer for settlement: $ _____

Insurer's loss reserve: $ _____

Deductible amount: $ _____

Is claim in suit? ☐ Yes ☐ No If "Yes", amount asked in summons: $ _____

If closed: Date closed: _____ ☐ Court judgment ☐ Out of court settlement ☐ Dismissed with prejudice ☐ Dismissed without prejudice

Total indemnity paid (including deductible): $ _____

Total defense costs/expenses paid: $ _____

Total costs incurred: $ _____

Provide complete and detailed information for evaluation. Use reverse side or additional sheets if required.

8. Condition and diagnosis at time of incidents (include dates of visits)

_____

_____

9. Description of treatment rendered (include dates of visits)

_____

_____

10. Condition of patient subsequent to treatment (include dates of follow-up treatment)

_____

_____

_____ _____ _____

Signature Print Name Date