DENTIST'S ADVANTAGE
PROFESSIONAL LIABILITY & PRACTICE PROTECTION

Thank you for choosing Dentist's Advantage! We look forward to working with you. Prior to completing the application, please review the tips below to ensure the quickest response from underwriting:

ALL QUESTIONS ON THE APPLICATION MUST BE ANSWERED

If you do not have the required information, please estimate responses to the best of your ability.

Section D:

- If you are the practice owner or have a legal entity (i.e. for tax purposes, etc) please answer all questions in Section D.
- If you are *not* a practice owner and *do not* have a legal entity, please mark N/A for questions 1-2.

Section H: Explanation required for any "Yes" responses.

- If you answered "Yes" to question 1 or 3(a), please complete a Supplemental Claim Information sheet for each claim or board complaint, found on the last page of the application.

Section I:

- Dentist's Advantage cannot quote Business Owners or Workers Compensation at this time.
- Cyber Liability is available.

Please be sure to include a copy of your current policy's Declarations Page. If you do not have current coverage, please provide an explanation.

Dentist's Liability Application

AMERICAN CASUALTY COMPANY OF READING, PA
151 N. Franklin, Chicago, IL 60606

NOTICE: THERE MAY BE BOTH OCCURRENCE COVERAGES AND CLAIMS MADE COVERAGES IN THIS POLICY. CLAIMS MADE COVERAGE IS LIMITED TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED AND REPORTED IN WRITING TO US DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

A. GENERAL INFORMATION

Please type or print. EVERY ITEM MUST BE COMPLETED. If not applicable, write N/A. If additional space is required, please provide your answers on a copy of your practice letterhead.

1. RICHARD MILLER _____ M _____ DDS ☐ DMD ■
FIRST NAME LAST NAME

Mailing Address:

_____ _____ _____ _____ _____
STREET CITY COUNTY STATE ZIP

Practice addresses and percentage at each address (total percentage must equal 100%)

Primary: SEE LIST _____ _____ _____ _____ _____ _____
STREET CITY COUNTY STATE ZIP %

Other: _____ _____ _____ _____ _____ _____
STREET CITY COUNTY STATE ZIP %

Other: _____ _____ _____ _____ _____ _____
STREET CITY COUNTY STATE ZIP %

2. Contact Information:

a. (781) 562-3442
BUSINESS PHONE NUMBER

b. _____
CELL PHONE NUMBER

c. kerstin@teamadm.com
E-MAIL ADDRESS

d. _____
FAX NUMBER

e. _____
WEB PAGE URL

B. COVERAGE INFORMATION

1. Are you entering practice for the first time? ☐ Yes ☐ No

2. Requested Policy Effective Date: 02/01/2021
MM / DD / YYYY

3. ☐ Claims Made Coverage **or** ☐ Occurrence Coverage

3a. If Claims Made Coverage: Please include a copy of your current Declarations Page AND provide retroactive date: _____
MM / DD / YYYY

3b. Date of Birth: _____
MM / DD / YYYY

4. Coverage Options: Please check the coverage Options and Limits you desire:

☐ **Option 1 Dental Professional Liability Only**

☐ **Option 2 Dental Professional Liability and Business Liability Coverages** including General Liability, Employee Benefits Liability, Employment Practices Liability*, Hired/Non-Owned Automobile Liability and Medical Waste Legal Expense Reimbursement (*Employment Practices Liability: $5,000 limit may be increased.) Please check with your agent for a quote.

☐ **Business Owners', Cyber Liability and Workers Compensation coverage can also be purchased. Please send me information.**

DENTAL PROFESSIONAL LIABILITY LIMITS

☐ $1,000,000/$3,000,000

☐ $1,300,000/$3,900,000 (NY Only) ☐ $2,000,000/$6,000,000 ☐ $3,000,000/$6,000,000

☐ $4,000,000/$6,000,000 ☐ $5,000,000/$6,000,000

Please check desired limit option above. NOTE: All limit options may not be available in all states.

5. List prior insurance carrier(s) for the past three (3) years. If none, state "None."

Name of Insurance Carrier	Effective Date	Expiration Date	Coverage Type	Limits of Liability
			☐ Claims-made ☐ Occurrence	
			☐ Claims-made ☐ Occurrence	
			☐ Claims-made ☐ Occurrence	

5b. Please explain any gaps in your insurance history: _____

6. Will you be providing dental services for which coverage is provided by another Professional Liability policy? . . . . . ☐ Yes ☐ No

If "Yes", please explain: _____

7. Are you now practicing, or have you ever practiced, without Professional Liability insurance . . . . . ☐ Yes ☐ No

If "Yes", please explain: _____

8. List all states where you hold, or have held, a Dental License even if the license is not currently active. (attach a separate sheet if needed)

State _____ License Number _____ Status of License (e.g., active, inactive, pending, etc.) _____

9. Consent Waiver **(May not be available in all states)**: Do you wish to waive the provision in the policy requiring us to obtain your consent in order to settle a claim against you? (Note: A premium credit may apply. Not available in all states.) . . . . . ☐ Yes ☐ No

C. EDUCATION

1. Are you a General Dentist? . . . . . ☐ Yes ☐ No

2. Are you a specialist? . . . . . ☐ Yes ☐ No
If so indicate below:

☐ Periodontist ☐ Prosthodontist ☐ Endodontist
☐ Pediatric Dentist ☐ Orthodontist ☐ Oral Pathologist
☐ Oral Surgeon ☐ Public Health Dentist ☐ Oral Radiologist
☐ Fulltime Faculty non-intramural

3. Are you a current member of the AGD? . . . . . ☐ Yes ☐ No

a. If Yes, AGD Membership Number _____
b. AGD Fellowship? . . . . . ☐ Yes ☐ No
c. AGD Mastership? . . . . . ☐ Yes ☐ No

4. Are you a member of any dental organization(s)? . . . . . ☐ Yes ☐ No
If "Yes" please provide the name(s) of the organization(s):

_____

_____

5. List your training and education.
(If more space is required, use a sheet of practice letterhead).

a. _____ _____
U.S. DENTAL SCHOOL/DEGREE DATE COMPLETED

_____ _____ _____
CITY STATE COUNTRY

b. _____
PROGRAM

c. Are you a Foreign Dental School Graduate? . . . . ☐ Yes ☐ No

_____ _____
NAME OF FOREIGN DENTAL SCHOOL DATE COMPLETED

_____ _____
COUNTRY PROFESSIONAL DEGREE

d. _____ _____
RESIDENCY LOCATION DATE COMPLETED

e. _____
POST GRADUATE CERTIFICATION

f. _____
SPECIALTY

g. _____ _____
SPECIALTY LICENSE # (IF APPLICABLE) DATE COMPLETED

6. Board Certification: In what area(s) if any are you Board Certified?

_____ DATE: _____ ☐ N/A
BOARD CERTIFIED MM / DD / YYYY

7. Drug License: _____
DEA NUMBER

D. YOUR PRACTICE

1. A. Name of your legal entity (if any): _____

B. Is the sole function / purpose of this entity for the practice of dentistry? . . . . . ☐ Yes ☐ No

If "No", please provide details (attach a separate sheet if necessary): _____

_____

C. If you have a legal entity, do you desire shared or separate limits of liability to apply to your legal entity?

☐ Shared (limits are shared with you at no cost)

☐ Separate (entity has its own set of limits and an additional charge applies)

D. Excluding yourself, name all officers or partners of your legal entity **:

_____

2. IF you own your own practice, please provide the number of the following who work for or with you (If none, please write "none" or "0"):

A. Employee dentists (other than yourself and/or partners/corporate officers) ** _____

B. Independent contractor dentists ** _____

C. All other employees (hygienists, assistants, technicians, clerical, etc.) _____

** NOTE: For all employee dentists, independent contractor dentists, and/or other officers or partners of your legal entity, a separate application OR proof of current Professional Liability coverage must be attached for each.

3. Not including practice partners, employees and independent contracting dentists as indicated above, are you in a space-sharing arrangement or agreement with another Dentist, Oral Surgeon, or other Healthcare Provider? . . . . . ☐ Yes ☐ No

If "Yes", please provide the following:

A. Name(s) and specialty of those with whom you are space-sharing:

Name _____ Specialty _____

Name _____ Specialty _____

B. Please attach proof of current Professional Liability insurance for each individual listed in section A. above.

C. Are patient charts for all space-sharing individuals kept in or retrieved from the same area? . . . . . ☐ Yes ☐ No

4. Do you now, OR have you within the past 5 years, provided professional services in a setting other than your office? (i.e., spa; residence; school; jail; prison; correctional facility; detention center; halfway house or similar type of facility for adults and/or juveniles; etc.) . . . . . ☐ Yes ☐ No

If "Yes", provide a summary of activities and total number of hours per month: _____

_____

_____

_____

5. Please provide patient makeup in the following categories. Please indicate "0" or "N/A" if none:

Direct pay by patient and/or fee for service: _____% Medicaid** patients: _____%

Managed care HMO / PPO / IPA: _____% Other:_____% Please describe: _____

****If** your practice (or the practice you work for) is currently reimbursed for providing services to Medicaid patients, please provide the following:

A. Number of adult Medicaid patients you see per year: _____ Number of pediatric Medicaid patient visits per year _____

B. Is the practice owned by a private equity group or is it a subsidiary of another practice? . . . . . ☐ Yes ☐ No

IF "Yes", please provide the name of the entity/entities: _____

C. Do you provide treatment to Pediatric Medicaid patients in a mobile dental office or school?. . . . . ☐ Yes ☐ No

IF "Yes", please provide details as to procedures provided: _____

PLEASE TELL US ABOUT YOUR PRACTICE – Continued

6. Does your practice include mobile dentistry? . . . . . ☐ Yes ☐ No

If "Yes", please answer the following questions:

A. Do you have a separate business entity / corporation set up for this purpose? . . . . . ☐ Yes ☐ No

If "Yes", business entity / corporation name: _____

B. Will dentists other than yourself be providing professional services on behalf of the mobile dentistry service?. . . . . ☐ Yes ☐ No

If "Yes", number of dentists: _____

C. What type of patients will you be seeing (e.g., nursing home patients, ACLF patients, school children etc.)? _____

_____

D. If further treatment is required, is a protocol in place to instruct the patient, or Guardian thereof, to seek follow up care? . . . . . ☐ Yes ☐ No

E. Please provide additional comments to help us better understand your mobile dentistry practice: _____

_____

7. Do you practice Alternative (Holistic) dentistry? . . . . . ☐ Yes ☐ No

If "Yes", please explain: _____

8. Do you serve as a faculty member at a dental school? . . . . . ☐ Yes ☐ No

A. If "Yes", how many hours per day Week? _____

B. If "Yes", you may be eligible for a premium discount. Please include a letter from the school acknowledging your position.

C. Does the school provide you with insurance? . . . . . ☐ Yes ☐ No

D. What is the name of the School? _____

BASED UPON YOUR ANSWERS TO QUESTIONS 9 THROUGH 12 BELOW COMPLETION OF A SUPPLEMENTAL APPLICATION MAY BE REQUIRED.

9. Please provide the percentages (based on number of procedures) of procedures you perform which fall into the following CDT codes (must total 100%)*:

Dental Procedure	CDT Code	%
Diagnostic	D0100 – D0999	%
Preventive	D1000 – D1999	%
Restorative	D2000 – D2999	%
Endodontics	D3000 – D3999	%
Periodontics	D4000 – D4999	%
Prosthodontics (Removable)	D5000 – D5899	%
Maxillofacial Prosthetics	D5900 – D5999	%
Implant Services	D6000 – D6199	%
Prosthodontics (Fixed)	D6200 – D6999	%
Oral and Maxillofacial Surgery	D7000 – D7999	%
Orthodontics	D8000 – D8999	%
Adjunctive General Services	D9000 – D9999	%

*If you are performing any procedures not included in the chart above, please provide details including the percentage of time spent on those activities based on the number of procedures:

_____

_____

10. Please confirm if you currently perform any of the following dental techniques or procedures:

A. Sargenti, RC-2B, N2 . . . . . ☐ Yes ☐ No

B. Treatment for sleep apnea without a physician referral . . . . . ☐ Yes ☐ No

C. Derma fillers . . . . . ☐ Yes ☐ No

11. Do you examine your patients for oral cancer and/or use diagnostic or screening techniques for detecting oral cancer? . . . . . ☐ Yes ☐ No

12. Please indicate if you perform any surgical procedures below. . . . . ☐ Yes ☐ No

If "Yes," please estimate the percentage each surgical procedure bears to your total practice (based on numbers of procedures) on an annual basis. (Total does not necessarily need to equal 100%)

Surgical Procedure	**Estimated %**
Surgical Placement of Implants	_____ %
Extractions of bony impacted, or partially bony impacted teeth	_____ %
Other dental cosmetic procedures (excluding biopsies, but including TMJ)	_____ %
Periodontal surgery	_____ %
Other surgery, including non-dental procedures	_____ %

_____ (Describe)

E. OFFICE PROCEDURES

1. Please confirm your average number of patients per week _____ , and average number of practice hours per week _____.

If you are working less than 20 hours per week you may qualify for a part-time discount. Please explain on your letterhead a.) the reason for your part-time status, and b.) who will handle emergencies when you are out of the office?

2. What is your patient mix? Adults _____ % Children _____ %

3. Is emergency resuscitation equipment – oxygen, AED, pulse oximeter, and a basic emergency kit available on site? . . . . . ☐ Yes ☐ No

If "Yes", are all designated staff in the operatory trained in its use? . . . . . ☐ Yes ☐ No

INFORMED CONSENT

4. What type of Informed Consent do you use? ☐ Oral ☐ Written ☐ Both ☐ None

a. If oral, is chart noted, dated and initialed by the patient? ☐ Yes ☐ No ☐ Not applicable

CONTROLLED SUBSTANCES

5. Has your DEA registration/application ever been denied, suspended, revoked, or surrendered?

☐ Yes ☐ No ☐ I do not prescribe controlled substances

6. When prescribing controlled substances, I inform patients of risks, benefits and alternative treatments; I do not prescribe amounts that would exceed FDA recommended daily dosage; I limit patient-specific controlled substance dosage quantities based on a comprehensive patient assessment, history and physical; I access the state prescription drug monitoring program (where permitted by law) for each new and renewed controlled substance; and, when I prescribe controlled substances for chronic pain care, I utilize patient agreements holding the patient/responsible party accountable to the treatment agreement.

☐ Yes ☐ No ☐ I do not prescribe controlled substances

MEDICAL HISTORY

7. Do you obtain a complete patient medical history? . . . . . ☐ Yes ☐ No

F. ANESTHETICS AND ANALGESIA

Please describe your use of anesthetics and types of analgesia in your practice as indicated below.
For purposes of this application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.

1. Do you use conscious sedation? . . . . . ☐ Yes ☐ No

2. Is IV, IM, sub-cutaneous or other injected forms of conscious sedation used? . . . . . ☐ Yes ☐ No

If "Yes", are you administering the sedation **and** performing the dental procedure? . . . . . ☐ Yes ☐ No ☐ Not applicable

3. Are you treating patients who are under general anesthesia (deep sedation)? . . . . . ☐ Yes ☐ No

If "Yes" are you administering the anesthesia **and** performing the dental procedure? . . . . . ☐ Yes ☐ No ☐ Not applicable

4. If you answered "Yes" to any of the questions 1– 4 above:

Are the procedures performed in a dental office? . . . . . ☐ Yes ☐ No

If "No" please indicate location _____

5. If you answered number 4 above "Yes", please indicate below or on your letterhead (if necessary) the type of agents used for each "Yes" answer, the frequency of use and by whom (yourself, MD Anesthetist, RN Anesthetist or other) the anesthesia is administered.

AGENTS	MODALITY	FREQUENCY	ADMINISTERED BY
AGENTS	MODALITY	FREQUENCY	ADMINISTERED BY

6. Do you provide treatment to any patient who has been sedated with chloral hydrate? . . . . . ☐ Yes ☐ No

G. OTHER EXPOSURE INFORMATION

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

If "Yes", please estimate percentage of work applicable to your own patients _____ %

2. Do you own, offer or operate any other business enterprise, either in conjunction with your practice or not? (e.g. spa services, consulting services, etc.) . . . . . ☐ Yes ☐ No

If "Yes", please describe: _____

_____

3. Are you currently under a contractual agreement where you have agreed to provide services to others? . . . . . ☐ Yes ☐ No

Please identify parties to the contract and describe services: _____

_____

4. Please identify any additional insureds requested to be named on the policy applied for:

LESSOR OF LEASED PREMISES _____

LESSOR OF LEASED EQUIPMENT _____

OWNER OF PREDECESSOR PRACTICE _____

OTHER, PLEASE EXPLAIN _____

H. CLAIMS AND EXPERIENCE INFORMATION

If you answer "Yes" to questions 1, 2 or 3 below, please provide on your letterhead the information requested below for each claim.

(a) Claimant's Name,
(b) Date of Alleged Error,
(c) Name of Insurer,
(d) If claim is closed, the total amount paid,
(e) If claim is pending, the claimant's demand amount and insurer's loss reserve,
(f) Description of claim including alleged error according to the claimant and your description of your treatment and extent of injury sustained.

1. Has there ever been a malpractice claim or suit filed against you or your corporation/partnership/association? ☐ Yes ☐ No

2. Do you know of any facts, circumstances, injuries, damages, acts, errors or omissions which may result in a malpractice claim against you, other dentists employed by you or your auxiliary staff? ☐ Yes ☐ No

If "Yes", have these been reported to a professional liability insurer? ☐ Yes ☐ No

3. Please answer the following. For any "Yes" answers, please explain on your letterhead.

a. Have you ever had any disciplinary action, restriction, suspension, probation or revocation of a license to practice dentistry? ☐ Yes ☐ No

b. Have you ever had any disciplinary action, restriction, suspension, probation or revocation of a license to administer or prescribe drugs? ☐ Yes ☐ No

c. Have you ever had any restriction, suspension, probation or revocation of privileges in any hospital or other health care facility? ☐ Yes ☐ No

d. Have you ever had any personal health problems (including alcoholism, drug addiction, mental illness or communicable disease)? ☐ Yes ☐ No

e. Have you ever had complaints filed against you involving the administration of Medicare/Medicaid or patient insurance? ☐ Yes ☐ No

f. Other than traffic violations, have you ever been convicted of a crime? ☐ Yes ☐ No

g. Have you ever been declined or cancelled for any Dental Professional Liability Insurance? **(Missouri residents: Do not respond)** ☐ Yes ☐ No

h. Have you ever been denied membership or participation in any health maintenance or similar organization? ☐ Yes ☐ No

If you are applying for Business Liability Coverage in addition to Professional Liability Coverage, please answer the following questions.

4. Have any claims been made against you in the last five years arising out of:

a. Liability for your office premises including damages from water or fire to leased premises? ☐ Yes ☐ No

b. Liability arising out of the use of automobiles not owned by you? ☐ Yes ☐ No

c. Claims for benefits for your employees arising out of your administration of those benefits? ☐ Yes ☐ No

d. Allegations of sexual harassment, unfair discrimination or other wrongful employment practices? ☐ Yes ☐ No

e. Violation of any rule or law regulating the disposal of medical wastes? ☐ Yes ☐ No

I. PREMISES INFORMATION AND PAYROLL

For a Business Owners or Workers' Compensation quote, please complete the following:

1. Is this a home-based business? ☐ Yes ☐ No

2. What do you want to insure? ☐ A building you own ☐ A building you own and its contents ☐ Equipment and contents in leased space

3. Enter the square footage occupied by the business: _____

4. Number of stories: _____

5. Enter the year the building was constructed: _____

6. If older than 20 years, please provide update history by year _____

7. Contents limit for Business Personal Property: _____

8. Please check the type of building construction (check only one):
☐ Frame ☐ Joisted Masonry ☐ Non-Combustible ☐ Masonry Non-Combustible ☐ Fire Resistive

9. Enter all relevant job descriptions and the total payroll for each description.

_____

_____

_____

10. Do you wish to add Cyber Liability* to your Professional Liability quote? ☐ Yes ☐ No. If yes, please select a limit below:

Limits of Liability	Premium
☐ $10,000	$100
☐ $25,000	$150
☐ $50,000	$300
☐ $100,000	$600

*May not be available in all states

Please read the following Representations carefully and sign and date this application on Page 9.
Applications can not be accepted without a valid signature.

Representations

By signing this application you, the applicant, agree with us, the Company that:

A. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have divulged any and all such situations in Section H. 1 and 2 of this application; and

B. The application and attachments, and all of the statements and answers given therein are:

1. Accurate and complete to the best of your knowledge;
2. Representations you are making on behalf of all persons and entities proposed to be covered;
3. A material inducement to us to provide a proposal for insurance and any policy issued by us is issued in specific reliance upon these representations; and

C. You agree to report to us in writing any material change in your operations, conditions, or answers provided in this application that may occur or be discovered after the completion date of the application and before the effective date of the policy. On receipt of such written notice, we have the right to modify or withdraw any proposal for insurance we have offered, at our sole discretion.

D. You authorize us, our agents and representatives to secure claims information from your current and previous insurance carriers.

E. The discovery of any fraud, intentional concealment, or misrepresentation of material fact will render this Policy, if issued, void at inception.

F. If this application is for Claims Made coverage, only claims first made against you and reported to us during the policy period or any applicable extended reporting period are covered, subject to the policy provisions.

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA 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 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 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 AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

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 KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWEDLGE 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 MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO 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 MAINE APPLICANTS: 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 OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: 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.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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 FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 THE PURPOSE 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 RHODE ISLAND 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 TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

SIGNATURE

☐ I Accept

"By checking the "I Accept" button, the applicant hereby consents and agrees that their use of a key pad, mouse or other device to check the "I Accept" button constitute their "signature" acceptance and agreement as if actually signed by the Applicant in writing and has the same force and effect as a signature affixed by hand. Further, the Applicant agrees the lack of a certification authority or other third-party verification will not in any way affect the validity or enforceability of their signature or any resulting contract."

Signing of the application does not bind you or us.

Signed _____
(Applicant)

Date _____

Title _____
(must be signed by authorized officer)

Producer _____

License Number _____

Address _____

_____

PLEASE MAKE SURE THE FOLLOWING ITEMS ARE INCLUDED (as applicable):

- ☐ **A copy of your current declarations page (if new applicant)**
- ☐ **If you are currently insured, a copy of a current loss run from your current insurance carrier**
- ☐ **A copy of your Practice Letterhead**
- ☐ **Certificate of Insurance or copies of declaration pages for all independent contractors and/or employee Dentists**
- ☐ **Copy of your license**
- ☐ **Copy of your conscious sedation permit or license if applicable**
- ☐ **Copies of certificates for implant courses taken**
- ☐ **Current letter of faculty appointment**
- ☐ **Copy of all correspondence, orders, and stipulations you received from Dental Board**
- ☐ **If you have a claim(s), include the supplemental claim form(s) for each claim**
- ☐ **Copies proof of coverage for Employer, Hospital, Clinic, or Dental School**

Return completed application to:

Dentist's Advantage
1100 Virginia Drive | Suite 250
Fort Washington, PA 19034

Or fax it to 877.250.1527

Questions? Call 888.778.3981

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. Allegation:

   _____

4. Date(s) of Treatment for Allegation: _____

   Location:

   _____

5. Date Claim/Suit Reported: _____

   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. Date Claim Closed or Suit Withdrawn: _____

9. Please provide narrative description of the case; including nature of treatment, your involvement, etc.

   _____

   _____

   _____

   _____

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

_____

Applicant's Signature Date

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