The Professional Protector Plan®
Application for Newly Graduated Dental Students

PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued. Additional Information may be required upon review of the application

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant in ink.

Requested Effective date: ____________________
MM / DD / YYYY

Type of Coverage requested: ❑ Claims Made

Policy Limits Requested – Professional Liability – Claims Made

❑ $ 1,000,000 / $ 3,000,000 ❑ $ 2,000,000 / $ 3,000,000 ❑ $ 2,000,000 / $ 4,000,000 ❑ $ 2,000,000 / $ 6,000,000

❑ $ 3,000,000 / $ 3,000,000 ❑ $ 3,000,000 / $ 6,000,000 ❑ $ 4,000,000 / $ 4,000,000 ❑ $ 5,000,000 / $ 5,000,000

❑ $ 5,000,000 / $ 8,000,000

Type of Coverage requested: ❑Occurrence

Policy Limits Requested – Professional Liability - Occurrence

❑ $ 1,000,000 / $ 3,000,000 ❑ $ 2,000,000 / $ 2,000,000 ❑ $ 2,000,000 / $ 6,000,000

PLEASE TELL US ABOUT YOURSELF

Full Name ______________________________ ❑DDS ❑DMD ❑MD ❑BDS ❑ MS

Mailing Address ______________________________

City/ State / Zip ______________________________

Email Address ______________________________ Telephone Number (______)__________________________

❑ Please check this box if you would like ‘Dental Expressions” (CNA’s quarterly Risk Management Newsletter) sent via email

Date of Birth ____________________

Dental School Attended ______________________________ Graduation ______________________________
MM / YYYY

Have you ever practiced before ? ❑Yes ❑No (if yes, a full application must be completed prior to coverage approval. The application can be obtained from your State Administrator)

Years in Practice ____________________

Did you complete a residency ? ❑Yes ❑No If “Yes” Specialty ____________________ Month / Year of Completion ____________________

Are you currently licensed to practice dentistry…………❑Yes ❑No State(s)____________________ License #(s)____________________

PLEASE TELL US ABOUT YOUR PRACTICE

Under which business structure do you practice?

❑ Sole Proprietor ❑ Partnership ❑ Employee ❑ Independent Contractor

How many hours per week do you practice (include lab work, patient visitation and consultation)? ____________________

If 20 hours or less, please complete a Part-time Supplement

PLEASE TELL US ABOUT YOUR SPECIALTY

Indicate your Practice Specialty (please check all that apply)

❑ General Dentistry ❑ Dental Radiologist ❑ Periodontics ❑ Oral/Maxillofacial Surgery ❑ Orthodontics ❑ Public Health
❑ Oral Radiology ❑ Prosthodontics ❑ Oral Pathology ❑ Pediatric Dentistry ❑ Endodontics

PLEASE TELL US ABOUT YOUR PARTICIPATION

Are you a member of your state dental association or society? .... ❑Yes ❑No

Have you taken one of the following risk management seminars? …………………………………… …………………………………………………….…. ❑ Yes ❑No

❑ CNA ❑ AAOMS / OMSNIC ❑ AAO ❑ NYSDA / DSSNY ❑ Henry Spenadel

Date of Attendance ______/______/______ If "**Yes**", provide evidence of attendance

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

ONLY IF APPLICABLE IF CLAIMS MADE IS SELECTED

I understand that my Professional Liability Coverage will be written on a "Claims-Made form" and acknowledge that this coverage will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" coverage will not provide insurance coverage for claims which occurred prior to the "Prior Acts Date" of my policy.

I understand that, should my "Claims-Made" policy with this insurance carrier ever be cancelled or non-renewed, or I decide to terminate it for any other reasons, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy, but were not reported to the insurance company before the date of the policy termination, I will be able to purchase additional insurance coverage.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (For District of Columbia residents only: 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.) (For Florida residents only: 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.) (For Louisiana residents only: 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.) (For Maine residents only: 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.) (For New York residents only: 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.) (For Oklahoma residents only: 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.) (For Pennsylvania residents only: 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.) (For Puerto Rico residents only: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousands dollars ($5,000) nor more than ten thousands dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.) (For Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Oregon and Vermont residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) (For Washington residents only: 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.)

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

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Signature in full: Date

REMINDER:
Please attach a sample of your letterhead and a copy of all of your dental practice "Yellow Pages" advertising, if any, to this application.

RETURN TO:

____
State Administrator Name

____
Address

____
City State Zip Code

Phone #: (______)____

Agent's License Number: ____

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