



**The Professional Protector Plan®**  
**Claims-Made**  
**Professional Liability Insurance For Dentists**



THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS, AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

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.
3. A copy of your letterhead must be included-

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

**I agree that any coverage issued will be contingent upon the truth of the following information:**

- New Policy Requested Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Rewrite of Policy Number \_\_\_\_\_

**PLEASE TELL US ABOUT YOURSELF**

1. Full Name: \_\_\_\_\_  DDS  DMD  MD  BDS  MS  
 2. Mailing Address: \_\_\_\_\_  
 City/ State / Zip \_\_\_\_\_  
 3. Email Address: \_\_\_\_\_ 4. Web Site: \_\_\_\_\_  
 Please check this box if you would like "Dental Expressions" (CNA's quarterly Risk Management Newsletter) sent via email  
 5. Telephone Number: (\_\_\_\_) \_\_\_\_\_ 6. Fax Number: (\_\_\_\_) \_\_\_\_\_  
 7. Dental School Attended: \_\_\_\_\_ 8. Month/Year of Graduation: \_\_\_\_\_  
 9. Did you complete a residency ?  Yes  No If "Yes" Specialty: \_\_\_\_\_  
 Month/year of Completion: \_\_\_\_\_  
 10. Are you entering practice for the first time?  Yes  No  
 11. Date of Birth: \_\_\_\_\_ 12. Years in Practice: \_\_\_\_\_  
 13. Are you currently licensed to practice dentistry..... Yes  No State(s): \_\_\_\_\_  
 License #(s): \_\_\_\_\_

**POLICY REQUEST INFORMATION – PROFESSIONAL LIABILITY**

14. Limits Requested:  \$ 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  Other: \_\_\_\_\_ (STATE EXCEPTIONS MAY APPLY)

**PLEASE TELL US ABOUT YOUR PRACTICE**

15. Under which business structure do you practice?

- Sole Proprietor     
  Limited Liability Company     
  Limited Liability Partnership  
 Incorporated     
  Partnership  
 Employee Dentist ..... Name of Employer/Facility: \_\_\_\_\_  
 Independent Contractor..... Name of Employer/Facility: \_\_\_\_\_  
 Faculty ..... Name of Employer/Facility: \_\_\_\_\_

If you own your practice, please complete the following:

- 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. Do you desire **Shared** or **Separate** limits of liability to apply to our 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- E. Please provide the number of the following who work for you:  
 **Employee Dentist** (other than yourself and / or partners/corporate officers) \* \_\_\_\_\_  
 **Independent contractor dentists** \* \_\_\_\_\_  
 **Other dentists** sharing facilities with you who are **not** covered under this policy) \* \_\_\_\_\_  
 \* **NOTE: For any of the ABOVE 3 selections**, be sure to attach a separate application or proof of professional liability coverage for each  
 **All other employees** (hygienists, assistants, technicians, clerical, etc.) \_\_\_\_\_

16. Practice Address and Percentage of Practice at each Address (**Total of Percentage Must Equal 100%**)

**Primary**

a)

Street	City	County	State	Zip	%

b)

Street	City	County	State	Zip	%

c)

Street	City	County	State	Zip	%

17. 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**

18. Indicate your Practice Specialty (please check all that apply)

- General Dentistry
- Endodontics
- Oral/Maxillofacial Surgery
- Oral Pathology
- Full-time Faculty-Non-Intramural
- Anesthesiology (Dental)-Conscious Sedation
- Dental Radiologist
- Oral Radiology
- Orthodontics
- Pediatric Dentistry
- Anesthesiology (Dental)-General Anesthesia
- Periodontics
- Prosthodontics
- Public Health

**PLEASE TELL US ABOUT THE PROCEDURES PERFORMED IN YOUR PRACTICE**

19. Which of the following procedures are performed by you or by someone under your supervision / direction:

- Sleep Apnea Therapy If **“Yes”**, please indicate the following:
  - I treat only after referral from physician
  - I treat without physician referral
  - I fabricate oral appliances for treatment of severe snoring & / or obstructive sleep apnea
- “Sargenti,” paste fill or formaldehyde based endodontic techniques **EXCLUDING** formocresol primary tooth pulpotomies
- IRREVERSIBLE** TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)
- Implant Surgery
- Extraction of Impacted teeth
- Implant Restoration
- Molar Endodontics on Permanent Teeth
- NONE OF THE ABOVE

20. Is the following performed by you or by someone under your supervision / direction ?

Cosmetic **dermal** procedures (including but not limited to Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.) .....  Yes  No

If **“Yes”**, please provide an explanation on a separate sheet of paper

**PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA**

**Anxiety Reduction** is defined as ‘the use of nitrous oxide / oxygen and/or oral premedication used in an accepted therapeutic dose to reduce anxiety’.

**Conscious sedation** is defined as “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 commands, produced by a pharmacologic or non pharmacologic method, or combination thereof’

**General Anesthesia and Deep Sedation** are defined as “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 purposely to physical stimulation or verbal command, produced by a pharmacologic method, or a combination thereof’

21. Are you treating patients who are under general anesthesia / deep sedation in your office ?  Yes  No
- If ‘YES’ who administers, the anesthesia ?
- You
  - Another Dentist, Anesthesiologist or CRNA (please provide proof of Professional Liability Coverage

**PLEASE TELL US ABOUT YOUR DENTAL LABORATORY / DENTAL IMAGING SERVICES**

22. Do you operate a dental laboratory? .....  Yes  No
- If **“Yes”** do you accept referrals for other than your patients? .....  Yes  No
- If **“Yes”** is there a separate business entity / corporation for this purpose ? .....  Yes  No

23. Do you provide radiology services for other than your patients or on a referral basis? .....  Yes  No
- “if **“Yes”** is there a separate business entity / corporation for this purpose ? .....  Yes  No

**PLEASE TELL US ABOUT YOUR PARTICIPATION**

24. Are you a member of your state dental association or society?.....  Yes  No
25. Have you taken one of the following risk management seminars in the last 3 years?.....  Yes  No
- CNA (Evidence not required if you are a CNA insured)       AAOMS/ OMSNIC       AAO  
 NYSDA / DSSNY       Henry Spenadel  
Date of Attendance \_\_\_\_/\_\_\_\_/\_\_\_\_ If "**Yes**", provide evidence of attendance

**PLEASE TELL US ABOUT YOUR LICENSE AND CLAIMS HISTORY**

- 26.A. Have you had a change in the status of your hospital privileges? .....  Yes  No  
If "**Yes**", provide details on a separate sheet of paper.
- B. Has any governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions? .....  Yes  No  
If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.
- C. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency? .....  Yes  No  
If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.
- D. Have you been convicted of any criminal charges? .....  Yes  No  
If "**Yes**", provide details from investigating agency.
- E. Have you ever been or are you currently being treated for:  
Alcoholism .....  Yes  No  
Drug Addiction, .....  Yes  No  
Mental Illness .....  Yes  No  
Physical Impairment? .....  Yes  No  
If "**Yes**", provide a letter from treating physician with complete details.
- F. Are you now, or have you ever, practiced without professional liability insurance?.....  Yes  No  
If "**Yes**", provide details on a separate sheet of paper.
- G. Have you ever had any professional liability insurance refused, cancelled or non-renewed?.....  Yes  No  
If "**Yes**", provide details on a separate sheet of paper. **THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS**
- H. Has any claim or suit for alleged malpractice ever been brought against you? .....  Yes  No  
If "**Yes**", please complete Supplemental Claim form.
- I. Are you currently aware of any situation that could lead to a malpractice suit against you?  Yes  No  
If "**Yes**", please complete Supplemental Claim form.

**PLEASE TELL US ABOUT YOUR INSURANCE HISTORY**

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

Insurance Carrier	Eff Date	Exp Date	Claims-made or Occurrence	Limits of Liability
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

28. Are you applying for prior acts coverage from CNA ?.....  Yes  No  
 If "**Yes**", please attach a copy of your last declaration page (face sheet).

29. Prior Acts date (Retroactive date) used by your previous carrier \_\_\_\_\_

30. Was an extended reporting endorsement (tail) purchased from your previous carrier ?.....  Yes  No

**PLEASE TELL US ABOUT YOUR GENERAL LIABILITY NEEDS**

**If "No" General Liability is requested, please continue to the next page**

28. Do you desire General Liability Coverage?  Yes  No (GL Limits are equal to your Professional Liability Limits but state exceptions may apply)

29. Do you desire Shared or Separate Limits of liability to apply to each location:  
 **Shared** (Limits are Shared with each location at no additional cost )  
 **Separate** (each location has its own set of limits and an additional charge applies)

30. Have you had any general liability losses in the past **three (3)** years?.....  Yes  No  
 If "**Yes**", provide date(s) of loss and detail(s) \_\_\_\_\_

31. Do you desire ERISA Fiduciary Liability Coverage / Employee Benefits Liability? .....  Yes  No  
 Coverage is recommended if you sponsor any Employee Benefit Plan. This is NOT the bond for your pension plan. Coverage is written on a Claims-made basis.  
 If "**Yes**", check the desired Limits of Liability:  \$ 100,000  \$ 250,000  \$ 500,000  
 \$ 750,000  \$ 1,000,000

32. If you are a tenant would you like to increase the standard \$ 500,000 Fire / Water / Legal Liability Limits?  Yes  No  
 If "**Yes**", check the desired Limits of Liability:  \$ 750,000  \$ 1,000,000

33. If your equipment lease or rental requires you to name the equipment lessor as an additional insured, please provide the name and address of the lessor as it appears on the lease or rental agreement.

34. If your building lease requires the building owner to be included as an additional insured for the portion of the premises leased to you, please list the Lessor's name and address as it appears on your lease:

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.

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.)

### RE M I N D E R

- Copy of letter head**
- Part time supplement – if requesting part time credit**
- Evidence of Risk Management attendance – if requesting RM credit**
- “Yes” responses to certain questions require attachment of additional documents, are these attached ?**
- Claim supplemental form must be completed for each claim, incident and / or suit in which you have been involved in**
- Copy of prior carrier dec page – if applying for prior acts coverage**

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

Signature in full:

Date

Agent's Signature:

Date

<b>RETURN TO:</b>		
_____		
State Administrator Name		
_____		
Address:		
_____		
City:	State:	Zip Code
Phone #: (____) _____		
Agent's License Number: _____		

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