PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®

Professional & General Liability Insurance for Dentists - Washington

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

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.

Requested Effective Date:____/____/____ ☐ **New Policy** ☐ **Rewrite of Policy Number:**_____

PLEASE TELL US ABOUT YOURSELF

1. Full Name:_____ ☐ DDS ☐ DMD ☐ MD ☐ BDS ☐ MS

2. Mailing Address:_____

City / State / Zip:_____

3. E-mail Address:_____ **4. Website:**_____

5. Would you would like the PPP's quarterly Risk Management Newsletter sent via email? ☐ Yes ☐ No

6. Telephone Number: (_____**)**_____ **7. Fax Number: (**_____**)**_____

8. All Dental Schools Attended:_____ **9. Month / Year of Graduation:**_____

10. Did you complete a residency?..... ☐ Yes ☐ No

If "**Yes**", Specialty:_____ Month / Year of Completion:_____

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

12. Have you ever practiced dentistry outside of the United States and / or its territories?..... ☐ Yes ☐ No

If **"Yes",** please explain: _____

13. Date of Birth:_____ **14. Years in Practice**:_____

15. How many hours per week do you practice (include administrative duties, record keeping, lab work, patient visitation and consultation)?_____**

**If 20 hours or less, please complete a Part-time Supplement provided by your agent.

16. Under which business structure do you practice?

☐ Sole Proprietor ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Incorporated ☐ Partnership
☐ Employee Dentist ☐ Independent Contractor ☐ Faculty (**Occurrence** coverage only) ☐ Volunteer (**Occurrence** coverage only)

If applicable, please list name of Employer / Facility: _____

If you volunteer, please describe volunteer services provided: _____

If you volunteer, will you receive remuneration for your volunteer services? ☐ Yes ☐ No

17. Practice addresses and percentage of practice at each address (total of percentages must equal 100%):

A. Primary: _____
Street City County State Zip Code %

B. _____
Street City County State Zip Code %

C. _____
Street City County State Zip Code %

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

☐ General Dentistry ☐ Dental Radiologist ☐ Periodontics ☐ Oral / Maxillofacial Surgery ☐ Dental Anesthesiologist
☐ Endodontics ☐ Oral Radiology ☐ Prosthodontics ☐ Pediatric Dentistry ☐ Full-time Faculty-Non-Intramural

☐ Orthodontics ☐ Public Health ☐ Oral Pathology ☐ Other - describe:_____

PLEASE TELL US ABOUT YOUR PROFESSIONAL LIABILITY COVERAGE NEEDS

19. Select the Professional Liability coverage type and limits desired. All limits may not be available in all states (select either Claims-Made or Occurrence):
PLEASE CONTACT YOUR AGENT IF HAVE ANY QUESTIONS REGARDING THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE AS WELL AS FOR DETAILED INFORMATION REGARDING AN EXTENDED REPORTING PERIOD AS IT RELATES TO CLAIMS-MADE COVERAGE.

☐ **Claims-Made Coverage****

☐ $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 / $6,000,000 ☐ $5,000,000 / $8,000,000
☐ Other _____
(STATE EXCEPTIONS MAY APPLY)

**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.

☐ **Occurrence Coverage**

☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $2,000,000 ☐ $2,000,000 / $6,000,000 ☐ Other _____
(STATE EXCEPTIONS MAY APPLY)

20. If Claims-Made Coverage is desired, please complete the following:

A. Are you applying for prior acts coverage from AAIC? ..... ☐ Yes ☐ No

B. Retroactive Date / Prior Acts Date on your current Claims-Made policy**: ____/____/____

****If prior acts is desired, please attach a copy of your last declaration page (face sheet)

C. Was an Extended Reporting Endorsement (tail) purchased from your previous carrier? ..... ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR GENERAL LIABILITY NEEDS

21. Do you desire shared or separate limits of liability to apply to each location (limits will be equal to your professional liability limits):

☐ 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)

22. Have you had any general liability losses in the past 3 years? (If **"Yes",** please provide a summary of the loss and claim amount) ☐ Yes ☐ No

_____

23. Do you desire to increase your limit of liability for ERISA Fiduciary Liability Coverage / Employee Benefits Liability above the included $25,000?☐Yes ☐No

Coverage is recommended if you sponsor an 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 limit of liability: ☐ $100,000 ☐ $250,000 ☐ $500,000 ☐ $750,000 ☐ $1,000,000

24. If you are a TENANT, would you like to increase the standard $500,000 Fire / Water Legal Liability Limit? ..... ☐ Yes ☐ No

If **"Yes",** check the desired limit of liability: ☐ $750,000 ☐ $1,000,000

25. If you have an equipment lease, building lease, rental agreement, etc. that requires you to name an entity as an additional insured for general liability purposes, please provide the name and address of the entity as it appears in your contract/agreement:

_____

PLEASE TELL US ABOUT YOUR OTHER LIABILITY NEEDS

26. Standard Employment Practices Liability Defense Coverage Only; limits: $25,000 Each Claim, $25,000 Annual Aggregate (coverage is automatically provided unless a STATE EXCEPTION APPLIES).

Do you wish to amend the standard coverage type from Defense Only to Indemnity and Defense (an additional charge will apply)? ☐ Yes ☐ No

If "Yes", please complete the **Employment Practices Liability Indemnity Supplemental Application** provided by your agent.

27. Standard Cyber Liability Coverage (coverage and limits outlined below are automatically provided at no charge unless a STATE EXCEPTION APPLIES):

Coverage	Limit Per Occurrence	Aggregate Limit	Total Aggregate Limit	Deductible
Network Extortion	$5,000	$50,000	$150,000	$1,000 deductible applies to all coverages except Privacy Event Expense.
First Party Loss	$100,000	$100,000		
Privacy Event Expense	$5,000	$5,000		
Regulatory Investigations	$50,000	$100,000		
Privacy Regulatory Proceedings, Network Security and Privacy Injury	$50,000	$150,000		

Do you wish to increase the Cyber Liability aggregate limit to $1,000,000 (an additional charge will apply)? ☐ Yes ☐ No

If "Yes", please complete the **Supplemental Application for Information Risk Coverage** provided by your agent.

PLEASE TELL US ABOUT THE PROCEDURES PERFORMED IN YOUR PRACTICE

28. Which of the following procedures are performed by you?

☐ Sleep Apnea Therapy or ☐ Fabrication of Snore Guards Only

If Sleep Apnea Therapy is more than snore guards, please indicate the following:

I treat only after referral from physician ☐ Yes ☐ No

I treat without physician referral ☐ Yes ☐ No If **"Yes"**, please provide a written explanation.

☐ **IRREVERSIBLE** TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)

	Informed Consent Type	**Training**
☐ Implant Placement/Uncovering/Surgery	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Partially Impacted Third Molar Extractions	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Fully Impacted Third Molar Extractions	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Molar Endodontics on Permanent Teeth	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Mini-Implants	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Conscious Sedation	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ **None of these**		

A. Have you discontinued any procedures listed above in the last five years? ☐ Yes ☐ No

Which procedures? _____

29. Do you or someone under your supervision/direction perform elective 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.

30. Are you treating patients who are under general anesthesia / 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 purposely to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof)? ☐ Yes ☐ No

If **"Yes",** where is the treatment provided? ☐ Your office ☐ Hospital or licensed / regulated surgical center

If administered in **your office**, who administers the anesthesia? ☐ Yourself ☐ Another Dentist, Anesthesiologist, or CRNA **

** Please provide proof of current Professional Liability coverage

PLEASE TELL US ABOUT YOUR PARTICIPATION

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

If **"Yes"**, provide name of association / society: _____

32. Have you taken one of the following risk management seminars in the last 3 years? ..... ☐ Yes ☐ No

If **"Yes"**, please indicate which one and provide evidence of attendance:

☐ PPP (Evidence not required if you are a PPP insured) Date of Attendance: _____/_____/_____

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

PLEASE TELL US ABOUT YOUR LICENSE HISTORY

33. 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.)**

34. A. Has any professional conduct or fee complaint ever been filed against you with any licensing or regulatory authority? (State licensing board; DEA; OSHA; EEOC; peer review committee; etc.) ..... ☐ Yes ☐ No

If "**Yes**", provide a copy of the board transcript or other documentation, including resolution and dates.

B. Have you, your legal entity, or any of your employees ever had any allegations, convictions, or related fines for Medicaid Fraud? ☐ Yes ☐ No

B. Has any governmental agency, including a state licensing board, investigated you or taken action against either your dental and/or narcotics license, including suspension, revocation, probation, restriction, denial, or other sanction? ..... ☐ Yes ☐ No

If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.

C. Have you been charged with or convicted of any criminal charges (including a DUI, OWI, etc., not including minor traffic violations)? ☐ Yes ☐ No

If **"Yes",** please provide details from investigating agency.

D. Have you ever had hospital or ambulatory surgical facility privileges involuntarily revoked, suspended or otherwise terminated? ☐ Yes

If **"Yes"**, please provide details on additional sheet of paper.

E. Have you ever been or are you currently being treated for (if **"Yes**" to any, please provide a physician's statement**)**:

Alcoholism..... ☐ Yes ☐ No

Drug Addiction..... ☐ Yes ☐ No

Mental Illness..... ☐ Yes ☐ No

Physical Impairment..... ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR PROFESSIONAL LIABILITY CLAIMS HISTORY

35. A. Has any claim or suit for alleged malpractice ever been brought against you? ..... ☐ Yes ☐ No

If **"Yes"**, please complete a Claim Supplement.

B. Are you currently aware of any situation that could lead to a malpractice suit against you? ..... ☐ Yes ☐ No

If **"Yes"**, have you reported the situation to your current insurer? ..... ☐ Yes ☐ No

If **"Yes"**, please complete a Claim Supplement.

PLEASE TELL US ABOUT YOUR DENTAL LABORATORY / DENTAL IMAGING SERVICES

36. Do you operate a dental laboratory? ..... ☐ Yes ☐ No

If "**Yes**", do you accept referrals of patients from other dentists? ..... ☐ Yes ☐ No

If "**Yes**", is there a separate business entity / corporation for this purpose? ..... ☐ Yes ☐ No

37. Do you provide radiology services to patients of other dentists? ..... ☐ Yes ☐ No

If "**Yes**", is there a separate business entity / corporation for this purpose? ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR PRACTICE

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

Please list any associated "dba" or fictitious entity name: _____

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) ***Shared limits not allowed in CT*

☐ Separate (entity has its own set of limits and an additional charge applies) ***Separate limits not allowed in IN*

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

_____

39. 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.**

40. Not including practice partners, employees and independent contracted 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**
_____	_____
_____	_____

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

41. 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: _____

_____

_____

42. 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: _____

_____

43. Do you practice Holistic dental services? ☐ Yes ☐ No

What percentage of your practice is Holistic?_____If **"Yes"**, please explain: _____

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

44. 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	

Please explain any gaps in your insurance history: _____

_____

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

If **"Yes"**, please explain: _____

_____

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

If "**Yes**", please explain: _____

_____

47. Have you ever had any Professional Liability insurance refused, canceled, or non-renewed? ☐ Yes ☐ No

THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS

If **"Yes"**, please explain: _____

AUTHORIZATION

I HEREBY ACKNOWLEDGE THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I AGREE THAT ANY COVERAGE ISSUED WILL BE CONTINGENT UPON THE TRUTH OF THE PRECEDING INFORMATION. I ACKNOWLEDGE THAT I AM AWARE THAT IF AT ANY TIME IT IS DISCOVERED ANY OF THE STATEMENTS OF FACT CONTAINED IN THIS APPLICATION ARE KNOWINGLY FRAUDULENT, AND THAT SUCH STATEMENTS WERE MATERIAL TO THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED, OR THE INSURER IN GOOD FAITH WOULD NOT HAVE ISSUED THE POLICY OR HAVE ISSUED IT DIFFERENTLY IF THE TRUE FACTS WERE KNOWN, THE POLICY MAY BE MODIFIED, RESCINDED, OR DECLARED VOID FROM ITS INCEPTION AND IN ACCORDANCE WITH APPLICABLE STATE LAWS. I HEREBY AUTHORIZE AAIC TO RELEASE THE INFORMATION ON THIS APPLICATION AND ASSOCIATED UNDERWRITING INFORMATION.

FRAUD NOTICE

NOTICE TO APPLICANTS OF WASHINGTON: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

REMINDER TO INCLUDE:

- ☐ **If no up to date website has been provided, please provide a copy of letterhead or business card (N/A if you are an Independent Contractor or Employee Dentist)**
- ☐ **Part time supplement – if requesting part time credit**
- ☐ **Employment Practices Liability Indemnity (EPLI) Supplemental Application – if requesting EPLI coverage** *(Defense only coverage is automatically included at a $25,000 sublimit)*
- ☐ **Evidence of Risk Management attendance – if requesting RM credit**
- ☐ **"Yes" responses to certain questions require attachment of additional documents/information; is this attached?**
- ☐ **Copy of prior carrier declarations page (if applicable)**
- ☐ **Claim Supplement (if applicable)**

ADDITIONAL INFORMATION MAY BE REQUESTED AND COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

Signature in full _____ Date _____

Agent's Signature _____ Date _____

If you apply your signature to this application electronically, you hereby consent and agree that your use of a key pad, mouse or other device to affect your electronic signature constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

PRE-FILL AGENCY INFORMATION

RETURN TO:

State Administrator Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____) _____ Agent's License Number: _____