



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. Also, please include a copy of all of your "Yellow Pages" advertising, if any.

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

LIMITS REQUESTED:		<input type="checkbox"/> New Policy	Requested Effective Date: ___/___/___
<input type="checkbox"/> \$1,000,000 / \$3,000,000	<input type="checkbox"/> \$3,000,000 / \$6,000,000		
<input type="checkbox"/> \$2,000,000 / \$3,000,000	<input type="checkbox"/> \$4,000,000 / \$4,000,000	<input type="checkbox"/> Rewrite of Policy Number: _____	
<input type="checkbox"/> \$2,000,000 / 4,000,000	<input type="checkbox"/> \$5,000,000 / \$5,000,000		
<input type="checkbox"/> \$2,000,000 / 6,000,000	<input type="checkbox"/> \$5,000,000 / \$8,000,000		
<input type="checkbox"/> \$3,000,000 / 3,000,000			
<input type="checkbox"/> Other: \$ _____ / \$ _____ (STATE EXCEPTIONS: IN, FL, KS, PR, SC, VA)		Website: _____	

PLEASE TELL US ABOUT YOURSELF

1. Name: (First/Middle Initial/Last/Designation) <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> MD <input type="checkbox"/> BDS		2. Date of Birth: _____	
3. Mailing Address: _____			
Street	City	State	Zip Code
4. Telephone Number: (____) _____		5. Fax Number: (____) _____	
		6. E-mail Address: _____	
7. Years in Practice: _____		8. Dental School Attended: _____	
		9. Month/Year of Graduation: _____	
10. Are you entering practice for the first time?.....			Yes No
If "Yes", did you complete a residency?.....			Yes No
Specialty: _____		Month/year of Completion: _____	
11. Under which business structure do you practice?			
<input type="checkbox"/> Sole Proprietor			
<input type="checkbox"/> Incorporated			
<input type="checkbox"/> L.L.C. or L.L.P.			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Employee Dentist		Name of Employer/Facility: _____	
<input type="checkbox"/> Independent Contractor		Name of Employer/Facility: _____	
If you own your practice, please complete the following:			
A. Name of your legal entity (if any): _____			
B. Do you desire shared or separate limits of liability to apply to your legal entity?			
<input type="checkbox"/> Shared (limits are shared with you at no cost)			
<input type="checkbox"/> Separate (entity has its own set of limits and an additional charge applies)			
C. Besides yourself, name all officers or partners of your legal entity: _____			

D. Please provide the number of the following who work for you:

Employee dentists (other than yourself and/or partners/corporate officers) _____
(attach a separate application or proof of professional liability coverage for each)

Independent contractor dentists _____
(attach a separate application or proof of professional liability coverage for each)

Other dentists sharing facilities with you who are **not** covered under this policy _____
(attach proof of professional liability coverage for each)

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

12. Practice Addresses and Percentage of Practice at Each Address (**Total of Percentages Must Equal 100%**):

Primary

1) _____
Street City County State Zip Code %

2) _____
Street City County State Zip Code %

3) _____
Street City County State Zip Code %

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

14. 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

15. Are you currently licensed to practice dentistry?..... Yes No
State(s): _____ License #(s): _____

16. Have you taken one of the following risk management seminars in the last 3 years?..... Yes No
θ CNA (Evidence not required if you are a CNA insured) θ Hartford θ AAOMS θ AAO θ Princeton θ NYSDA
Date of Attendance ____/____/____ If "**Yes**", provide evidence of attendance.

17. Indicate your Practice Specialty

<input type="checkbox"/> General Dentistry	<input type="checkbox"/> Oral Radiology	<input type="checkbox"/> Periodontics
<input type="checkbox"/> Endodontics	<input type="checkbox"/> Orthodontics	<input type="checkbox"/> Prosthodontics
<input type="checkbox"/> Oral/Maxillofacial Surgery	<input type="checkbox"/> Pediatric Dentistry	<input type="checkbox"/> Public Health
<input type="checkbox"/> Oral Pathology		<input type="checkbox"/> Full-time Faculty-Non-Intramural
<input type="checkbox"/> Anesthesiology(Dental)-Conscious Sedation	<input type="checkbox"/> Anesthesiology(Dental)-General Anesthesia	

18. Which of the following procedures are performed by you:

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

"Sargenti," paste fill or formaldehyde based endodontic techniques excluding formocresol primary tooth pulpotomies

Sleep Apnea Therapy If "**Yes**", please indicate the following:

I treat only after referral from physician I treat without physician referral I fabricate snore guard

Cosmetic **dermal** procedures (including Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.)
If "**Yes**", please provide an explanation on a separate sheet of paper.

None of the above

19. A. Have you ever 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 treated for alcoholism, drug addiction, mental illness or physical impairment? Yes No
If "**Yes**", provide a letter from treating physician with complete details.

PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA

20. **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 command, produced by a pharmacologic or non-pharmacologic method, or a 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 or non-pharmacologic method, or a combination thereof.”

A. 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 TELL US ABOUT YOUR INSURANCE HISTORY

21. Are you now, or have you ever, practiced without professional liability insurance?..... Yes No
 If “**Yes**”, provide dates and reason:

22. Have you ever had any professional liability insurance refused, cancelled or non-renewed?..... Yes No
 If “**Yes**”, provide dates and reason: **(THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS)**

23. Has any claim or suit for alleged malpractice ever been brought against you?..... Yes No
 If “**Yes**”, please complete Supplemental Claim form.

24. 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.

25. List prior carrier(s) for the past **three (3)** years. If none, state “None.”

Insurer	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

27. Prior Acts date (Retroactive date) used by your previous carrier _____

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

PLEASE TELL US ABOUT YOUR PREMISES/OPERATIONS

30. 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:

31. 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:

32. 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).

33. Do you desire ERISA Fiduciary/Employee Benefits Liability coverage?..... Yes No
 This is NOT the bond for your pension plan. (An additional premium charge is applicable)

34. Would you like to increase your Fire & Water Legal Liability limits? (\$500,000 included)..... Yes No
 (An additional premium charge is applicable) Coverage is written on an Occurrence basis.

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 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 Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For 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.

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: _____

The Professional Protector Plan® is a registered trademark of B & B Protector Plan, Inc.®. Coverage is underwritten by Continental Casualty Company, one of the CNA property/casualty insurance companies. CNA is a service mark registered with the US Patent and Trademark Office.

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 _____ Social Security Number: _____

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