PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®

Professional Liability Application for Newly Graduated Dental Students - Washington

DEPENDING ON THE COVERAGE YOU ELECT, THE POLICY YOU ARE APPLYING FOR MAY PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR DURING AN APPLICABLE EXTENDED REPORTING PERIOD.

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.
3. A copy of your letterhead must be included. (N/A if you are an Independent Contractor or Employee Dentist)

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 application.

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

PLEASE TELL US ABOUT YOURSELF

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

2. Mailing Address:_____

City / State / Zip:_____

3. E-mail Address:_____ 4. Telephone Number: (_____)_____

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

6. Date of Birth:_____ 7. Dental School Attended:_____ 8. Month/Year of Graduation:_____

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

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

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

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

12. Are you currently licensed to practice dentistry?..... ☐ Yes ☐ No

State(s):_____ License #(s):_____

PLEASE TELL US ABOUT YOUR PRACTICE

13. Under which business structure do you practice? ☐ Sole Proprietor ☐ Partnership ☐ Employee ☐ Independent Contractor ☐ Corporation

14. Practice Name (list State if you don't know where you will be practicing):_____

Practice Address / City / County / State / Zip:_____

PLEASE TELL US ABOUT YOUR SPECIALTY

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

☐ General Dentistry	☐ Dental Radiologist	☐ Endodontics	☐ Oral Radiology	☐ Oral / Maxillofacial Surgery
☐ Orthodontics	☐ Public Health	☐ Oral Pathology	☐ Pediatric Dentistry	☐ Full-time Faculty-Non Intramural
☐ Dental Anesthesiologist	☐ Periodontics	☐ Prosthodontics	☐ Alternative (Holistic) Dentistry	☐ Other:_____

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

	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**		

PLEASE TELL US ABOUT YOUR PARTICIPATION

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

18. Have you taken one of the following risk management seminars?..... ☐ Yes ☐ No

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

☐ PPP (Evidence not required if you are a PPP insured) ☐ AAOMS / OMSNIC ☐ AAO ☐ NYSDA / DSSNY ☐ Henry Spenadel ☐ CNA

Date of Attendance:_____/_____/_____

DESIRED COVERAGE

19. Requested Effective Date: ____/____/____

20. Type of Professional Liability Coverage Requested:

☐ Claims-Made

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

☐ Occurrence **(Not available for CA residents)**

Policy limits requested:

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

21. Do you desire General Liability coverage?..... ☐ Yes ☐ No

Additional charges will apply if GL is elected.

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.

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: Pacific Underwriters

Address: 12611 Des Moines Memorial Drive

City: Seattle State: WA Zip Code: 98168

Phone #: (800) 562-5226 Agent's License Number: 667674

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