Admiral INSURANCE GROUP
a Berkley Company

DENTIST'S PROFESSIONAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED COVERAGE)

1) Full Name of Applicant:

2) Degree:

3) Principal Practice Address:

4) Additional Practice Locations:

5) Home Address:

6) Website:

7) Social Security Number:

8) DEA Number:

9) Date of Birth:

10) Place of Birth:

11) Are you a U.S. Citizen? ◯ Yes ◯ No

If no, indicate your status and date of entry into the United States:

12) From what Dental School did you graduate?

City, State and Country of Dental School:

Degree: Year of Graduation:

If foreign medical school graduate, provide the date you began your practice in the United States:

13) Provide a detailed summary of where you have practiced since completing your training:

Address/City/State	Country	From	To

14) Indicate memberships in professional societies:

15) List the States and License numbers where you practice:

16) Type of practice (Check all that apply):

☐ Individual ☐ Employee ☐ Individual Corporation ☐ Partnership

☐ Member of Multi-person Corp or Assoc. – Specify Name of Entity:

☐ Other:

17) Do you want coverage for the entity named above? ◯ Yes ◯ No

18) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all dentists or oral surgeons practicing under the entity named above:

19) Do you practice with any dentists not named above? ◯ Yes ◯ No

If yes, provide the name of the dentist(s) and relationship to your practice?

20) Provide the names of all facilities that you practice at and your interest in each facility:

Name of Clinic or Facility and Location	Interest (Owner, Partner, Employee)

21) Are you seeking coverage for your work at all of the above facilities? ◯ Yes ◯ No

If no, list those facilities for which you do not require coverage and explain why coverage is not needed:

22) Provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage:

	Number Employed	Number Contracted	Carry their own Med Mal Policy?
Dentists (other than yourself)			◯ Yes ◯ No
Dental Assistants			◯ Yes ◯ No
Dental Technicians			◯ Yes ◯ No
Hygienists			◯ Yes ◯ No
Nurse Anesthetists			◯ Yes ◯ No
Anesthesiologists			◯ Yes ◯ No
Other:			◯ Yes ◯ No

Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.

Attach copies of Dec Pages on above professionals that carry their own malpractice policies.

23) Are all of the above individuals licensed in accordance with the applicable state and federal regulations? ◯ Yes ◯ No

If no, provide a detailed explanation below:

24) What is your dental specialty?

Do you limit your practice to the above specialty? ◯ Yes ◯ No

If no, provide details:

25) Are you American Dental Board certified in any specialty? ◯ Yes ◯ No

If yes, provide the Board(s) in which you are certified below: Year:

26) What is your total annual revenue? ☐ $100,000 or less ☐ $100,001 - $250,000 ☐ $250,000 - $499,999 ☐ $500,000 or more

27) Average weekly patient load:

28) Number of hours you practice each week:

29) Provide the approximate percentage of your practice in the following:

Bone Grafting	%	Pediatric Dentistry	%
Cosmetic Dentistry		Periodontics	%
Bonding	%	Prosthodontics	%
Enamel Shaping	%	Non-Dental Cosmetic Procedures (including injecting Botox and collagen fillers)	
Full Mouth Restoration - Cosmetic Only			
Veneers		Describe:	%
Whitening with Lasers	%	Prosthetics	
Other:	%	Fixed	%
Endodontics		Removable	%
Single Rooted	%	Sleep Apnea	
Multi Rooted	%	Surgery	%
Sargenti Root Canal Method	%	Therapy	%
General Dentistry		Surgery*	
Extractions of Impacted Teeth	%	Facial – Elective Cosmetic	%
Root Canal	%	Head and Neck	%
Simple Extractions Only	%	Oral/maxillofacial	%
Implants		Outside oral/maxillofacial region	%
Restoration	%	TMJ	
Placement	%	Non-surgical	%
Micro Neurosurgical Procedures		Surgery	%
Oral Pathology	%	Other:	%
Oral Radiology	%		
Orthodontics	%		
Orthognathic Procedures	%	**TOTAL**	100%

*Provide complete list of surgical procedures

30) Do you use written informed consent documents for all procedures? ◯ Yes ◯ No

If yes, attach a copy of all forms that are used. If no, describe below:

31) Do you wire jaws closed for purposes of weight loss? ◯ Yes ◯ No

If yes:

a. Number performed in the last 12 months?

b. Estimated number that will be performed in the coming year?

32) What percentage of your patients are under age 18? %

33) Do you perform any hospital emergency room care? ◯ Yes ◯ No

If yes, is this solely a requirement for active admitting privileges? ◯ Yes ◯ No

If no, provide a detailed description including the approximate number of yours per month spent in emergency room care:

34) Check all of the following procedures that you perform. For each procedure performed, indicate where the procedure is performed (H = Hospital; O = Office; S = Surgi-Center or Certified Surgical Suite)

Procedure	Location	Procedure	Location
Acupuncture	Select	Chemical Peel	Select
Adenoidectomy/Tonsillectomy	Select	Solution Strength:	Select
Anesthesia:	Select	Chin Surgery	Select
General	Select	Cleft Lip and Palate Surgery	Select
Twilight	Select	Cosmetic Implant of Silicone or other Material	Select
Other:	Select	Cosmetic Surgery	Select
Surgery Other:	Select	Cryosurgery	Select
Extractions:	Select	Dental Alveolar Surgery	Select
Non-Impacted Teeth	Select	Dermabrasion/Microdermabrasion	Select
Impacted Teeth	Select	Dermal Fillers	Select
Surgery and Other Procedures:	Select	Face Lift	Select
Biopsies:	Select	Hair Transplants or Suture of Hairpieces	Select
Blepharoplasty	Select	Laser Skin Resurfacing	Select
Botox Injections	Select	Pain Management (describe):	Select
Laser Surgery (describe):	Select		
	Select	Radiation Therapy	Select
Liposuction – above the neck (volume):	Select	Radiopaque Dye Injections into blood vessels, lymphatics, sinus tracts or fistulae	Select
	Select		
		Reconstructive Plastic Surgery (describe):	Select
Liposuction – below the neck:	Select		
Under 3500 cc's volume	Select	Rhinoplasty	Select
3500 cc's or more volume	Select	Sargenti Root Canal Method	Select
Nerve Grafts	Select	Sinus Lift	Select
Open Reduction of Fractures	Select	TMJ Surgery	Select
Cheek Implant	Select	Uvulopalatoplasty	Select

35) Is analgesia, sedation or anesthesia used on patients? ◯ Yes ◯ No

If yes, do you administer Local Anesthesia ONLY? ◯ Yes ◯ No

If Local Anesthesia only, please continue to Q36.

If no, and you administer other types of anesthesia, complete a Dentist's Anesthesia Supplemental Application.

36) Have you or any of your employees:

a. Ever been the subject of investigation or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? **Attach a copy of Complaint and Consent order document if applicable.** ◯ Yes ◯ No

b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ◯ Yes ◯ No

c. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric

treatment or has any administrative agency, hospital or professional association requested or required you to be evaluated for an alleged mental condition and/or alcohol or drug addiction? ◯ Yes ◯ No

d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked renewal refused or accepted only on special terms or ever voluntarily surrendered same? ◯ Yes ◯ No

e. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? ◯ Yes ◯ No

f. Ever failed any medical licensing or specialty organization examination? ◯ Yes ◯ No

g. Do you have any chronic illnesses or defects? ◯ Yes ◯ No

If yes to any of the above questions, provide full details below:

37) Do you anticipate any changes in your practice? ◯ Yes ◯ No

If yes, describe below:

38) List the prior medical malpractice insurance carried for each of the past 5 years beginning with the most current:

Company	Limit	Deductible	Premium	Policy Term	Retro Date

*Attach a copy of the declarations page of your most recent policy.

39) Do you own, operate or provide professional services for, or at, any dental or health care facility or business enterprise not already clearly described in this application? ◯ Yes ◯ No

If yes, describe:

40) Has any claim or suit for alleged malpractice been brought against you? ◯ Yes ◯ No

If yes, how many total claims or incidents?

Also attach 5 years of currently valued company loss runs.

41) Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? ◯ Yes ◯ No

If yes, complete the Supplemental Claim Information Form for each and every claim.

42) Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being brought against you? ◯ Yes ◯ No

If yes, provide details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident:

Please attach the following information:

- CV or Resume
- Five years of currently valued carrier loss runs
- Copies of any disciplinary actions, stipulations, orders or probation documents
- Copies of declarations pages for all employees or contractors that carry their own med mal
- Copy of applicant's most current declarations page

Provide any additional comments or details on a separate attachment.

RESET SAVE PRINT EMAIL

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: 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)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: 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 and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title: Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.