

Princeton Insurance

Dentist and Oral Surgeon Professional Liability Renewal Application

PARTNERSHIP. PREVENTION. PROTECTION.

COMPLETED RENEWAL APPLICATION REQUIRED FOR RENEWAL OF YOUR POLICY
(Please indicate any corrections or changes you wish to make.)

Policy Number _____ Policy Effective Date _____

1. Agency name and address _____

Phone _____ Fax _____

2. Name and mailing address of insured _____

Phone _____

Fax _____

E-mail _____

(will be used to provide policyholder information only.)

Website _____

3. Birthdate _____

4. License # for primary practice state _____

Practice Locations

5. List all locations where you currently and/or anticipate working; indicate number of hours worked

Employer/Facility Name	Street	City	State	Zip	Employee or Independent Contractor	Total Hours worked per week
1.						
2.						
3.						

**Includes patient care, hospital rounds, record keeping, administrative duties, teaching, house calls, nursing home visits, utilization review.*

6. Do you practice dentistry on patients to whom you have administered general anesthesia or deep sedation? Yes No

7. Do you employ any dental hygienists that administer local anesthesia? Yes No

If yes, please complete Supplemental Questionnaire for Dentists Employing Hygienists Administering Local Anesthesia

8. Do you practice dentistry on patients to whom someone else has administered parenteral conscious sedation/general anesthesia? Yes No

If yes, does the person administering the anesthesia possess a PCS permit? Yes No

Is he/she an M.D. or D.O. and a member of an accredited hospital? Yes No

Name: _____ (current certificate of insurance coverage must be provided)

9. Where are procedures on patients administered general anesthesia performed? (check all that apply)

In hospital In office Other _____

10. Do you practice dentistry on patients to whom you have administered parenteral conscious sedation -i.e., via any route other than enteral (oral)? Yes No

If yes, do you possess a PCS permit from the State Board of Dentistry? Yes No

11. Do you administer combination inhalation-enteral (oral) conscious sedation (i.e., conscious sedation using inhalation and enteral agents) for the purpose of deep sedation or analgesia (diminution or elimination of pain)? Yes No

12. Do you administer enteral (oral) sedation alone for the purpose of analgesia? (diminution or elimination of pain) Yes No
13. If you answered "yes" to any of the questions 10 through 12, do you adhere to the American Dental Association Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (October, 2003 and any revision thereof)? Yes No
14. Do you administer enteral (oral) sedation or combination inhalation-entereal (oral) sedation only for the purpose of anxiolysis (diminution or elimination of anxiety)? Yes No
15. Do you practice dentistry on patients to whom you have administered nitrous oxide alone and not in combination with any other systemic chemical agents? (excluding local anesthetic) Yes No
16. Do you perform the surgical placement of dental implants? Yes No
17. Do you perform the prosthetic or restorative component of dental implants? Yes No
18. Do you use filling materials or sealers containing sargenti paste? Yes No
19. If you perform oral surgery, do you obtain documented patient consent prior to performing surgery? Yes No
20. Do you inject derma fillers or administer Botox? Yes No
If yes, please provide a certificate of training from a NJ Board of Dentistry-approved course.

21. Indicate percentage of time devoted to the following dental activities

General Dentistry _____% (include simple extractions)
 Oral Surgery _____% If you are a General Dentist, please list the oral surgery procedures you perform _____

 Orthodontics _____%
 Other _____%

22. CLAIMS UPDATE

- Other than with Princeton, have any new claims been made against you? Yes No
- Other than with Princeton, have any previously open claims been closed without indemnity payment? Yes No
- Other than with Princeton, have any previously open claims been closed with indemnity? Yes No

If you answered "Yes" to any of the above claims questions, you must provide copies of updated loss runs from your prior carrier.

23. Do you have a position for which no coverage is required, or for which you are insured with another carrier? Yes No
If yes, indicate activity, entity and location to be excluded and indicate hours worked at this position only _____

If you answer yes to any of questions 24 through 32, please explain on a separate sheet and provide full documentation from any agency involved.

24. Do you provide any services over the internet? Yes No
25. Do you know of any circumstance, act, error or omission that could possibly result in a professional liability claim against you? Yes No
26. Do you anticipate any changes in staff or services provided in the next year? Yes No
27. Has any health care facility ever denied, suspended, revoked privileges or has probation been invoked? Yes No
28. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked? Yes No
29. Do you have a condition or engage in any activity, or use any substance (including alcohol, drugs or medications) which affects, impairs or limits your ability to practice medicine with reasonable skill and safety? Yes No
30. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? Yes No

31. Has a complaint against you ever been submitted to the State Board of Dentistry or are you currently under investigation by a regulatory authority? Yes No
32. Do you treat patients at a correctional Yes No
33. Do you participate as a principal investigator for any clinical trials? Yes No
If yes, do you follow FDA-approved protocols? Yes No
34. **Optional Waiver of Consent to Settle:** *1% discount to premium.* If you choose this option, your coverage will be changed. An endorsement will be attached to your policy giving the company the sole right to settle any claim as it deems appropriate. Would you like this option waiver applied to your policy? Yes No

Corporate Coverage Please complete if you own a professional corporation, professional association, or limited liability corporation

35. Is coverage desired for your professional entity? Yes No
If yes, name of entity _____
Federal Employer Identification Number _____
36. Does your entity employ any physicians, surgeons, podiatrists, dentists, chiropractors, physician assistants, surgical assistants, residents, nurse anesthetists, nurse midwives, nurse practitioners, nurse surgical assistants, clinical nurse specialists, perfusionists, social workers or psychologists? Yes No

If no, solo corporations must share the limits of liability of the individual.

If yes, a separate Appendix A - Staff Schedule and Appendix B - Organization Application must be completed and certificates of insurance and claims histories must be provided for each individual.

37. Is this a new entity formed within the last 12 months? Yes No

Section II Signature

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind Princeton Insurance Company to complete the insurance, but it is agreed that this application shall be the basis of a contract should a policy be issued. I authorize release and exchange of any underwriting or claims information between all prior carriers and Princeton Insurance Company.

Signature of policyholder _____ Date: _____

Print name of policyholder _____

I understand that Princeton Insurance Company reserves the right to reject any applicant that does not meet its underwriting standards.

NOTICE: 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.

Assignment of Unearned Premium

- 1. If the premium payer is other than the named insured, is the unearned premium assigned to the payer?
 - Yes Complete remainder of agreement and include both parties' signatures.
 - No

Agreement to Assign Unearned Premium

- 2. _____, hereinafter referred to as the Corporation and _____, referred to as the Medical Care Practitioner (MCP), hereby enter into this agreement.
 - a) Whereas the Corporation has agreed with the MCP to pay the cost of professional liability coverage for the MCP during the current policy term beginning _____ and may do so for subsequent renewals, and;
 - b) Whereas the premiums for professional liability insurance coverage for the MCP may be due and payable in advance for the policy period.

Now, therefore, the parties hereto agree to the following:

In consideration for the Corporation paying the premiums for said insurance, the MCP hereby:

- 1. Assigns and gives a security interest to the Corporation for any and all unearned premiums which may become payable from the professional liability policy paid for by the Corporation.
- 2. Irrevocably appoints the Corporation as the MCP's Attorney-In-Fact with full authority to cancel the MCP's professional liability policy purchased by the Corporation, receive all sums assigned to the Corporation or in which the MCP has granted the Corporation a security interest in furtherance of this agreement.
- 3. All legal rights given to the Corporation shall benefit the Corporation's successors and assigns and shall remain in effect until the MCP provides written notification of termination to both the Corporation and insurance company which issued the policy.
- 4. The MCP agrees not to further assign any interest in said professional liability policy without the Corporation's written consent.

Date _____

Date _____

Medical Care Practitioner signature

Corporation

Print name of policyholder

Officer

Home address*

Address of corporation

City, State, Zip*

Home phone number*

Witness to Medical Care Practitioner's signature

*This information will only be used for cancellation notification and extended reporting offers only.

Supplemental Questionnaire for Dentists Employing Hygienists Administering Local Anesthesia

Policyholder Name _____

1. Do you credential employed hygienists who administer local anesthesia to verify:
 - a. Current permit to administer local anesthesia? Yes No
 - b. Completion of required training and monitored local anesthesia administrations as required by NJ regulation? Yes No
 - c. Completion of continuing education required for local anesthetic permit renewal? Yes No

2. Do you maintain exclusive (non-delegable) responsibility for the selection of the anesthetic agent for each patient receiving local anesthesia injections by the hygienist? Yes No

3. Are you physically present (on-site) during each administration of local anesthesia to directly supervise the hygienist? Yes No

4. Do you have an established plan to address unanticipated outcomes of local anesthetic injection by the hygienist to include:
 - a. Notification to the patient of the occurrence? Yes No
 - b. Follow-up with the patient to determine whether or not the outcome is transient in nature or requires further evaluation? Yes No
 - c. Remedial training of the hygienist before performing additional injections? Yes No
 - d. Documentation of the occurrence in the patient's dental record? Yes No