Princeton Insurance
a MedPro/Berkshire Hathaway company

Dentist and Oral Surgeon Professional Liability Renewal Application

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 Indepdenent 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? (exluding 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 your 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.

Policyholder name ____

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