Dentist & Oral Surgeon Professional Liability Application

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Princeton Insurance
a MedPro/Berkshire Hathaway company

Dentist and Oral Surgeon Professional Liability Application

Section I General Information

1. Name and address of applicant

_____
_____
_____

Contact person _____
Phone (____) _____
Fax (____) _____
E-mail _____
(Will be used to provide policyholder information only.)

Website address _____

2. Agency name and address

_____
_____
_____
_____

Phone (____) _____
Fax (____) _____
Agent's Website address _____

3. Birth date_____ 4. Gender ☐ Male ☐ Female

5. Social Security # _____

6. License # and date for primary practice state _____

7. Type of coverage requested ☐ Claims-Made ☐ Occurrence

8. Requested effective date _____ ☐ Non-binding indication only ☐ Formal quote*

**If a formal quote is requested and it results in a declination, the declination will be reported to the Department of Insurance.*

9. Requested retroactive date _____ **If requesting prior acts coverage, the supplemental prior acts application must be completed and a copy of your current policy must be provided.**

Practice Locations

10. List all locations where you currently and/or anticipate working; indicate the number of hours worked per week

Employer/Facility Name	Street	City	State	Zip	Employee or Independent Contractor	Total hours worked *
1.						
2.						
3.						

**Includes patient care, hospital rounds, recordkeeping, administrative duties, teaching, house calls, nursing home visiits, utilization review.*

11. Name of present insurance carrier _____
Expiration date _____
Type of present policy (Attach copy of prior policy) ☐ Occurrence Plus (Modified Claims-Made) ☐ Occurrence ☐ Claims-Made
Loss runs from all prior carriers are required. If claims-made, was tail purchased? ☐ Yes ☐ No

12. Previous professional liability insurance carrier(s)

Company Name	Policy #	Coverage Date		Occurrence/Occurrence Plus/Claims Made	Retroactive Date
		Eff.	Exp.		

Applicant Name_____

If you answer yes to questions 13, 14 or 15, please provide full details on a separate sheet.

13. Have you ever practiced without professional liability coverage? ☐ Yes ☐ No

14. Has your professional liability coverage ever been written with a non-admitted carrier? ☐ Yes ☐ No

15. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? ☐ Yes ☐ No

16. If you are employed by someone else, please answer the following:
    a) Name of employer _____
    b) Name of employer's professional liability insurer_____
    (If your employer is to pay the premium for your coverage, refer to Assignment of Unearned Premium form.)

Section II Practice Information

1. List all facilities or organizations where you have practiced or have had staff or courtesy privileges for your profession since graduation. (Explain any periods of inactivity)

Facility Name and Location	Department	Type of Privileges	Dates From/To

2. List all states in which you are licensed or have been licensed and information on that state license if applicable:

State	License #	DEA License #	Active Yes/No	# of Patients	% of Hospital Procedures	% of Income	% of Office Hours

3. 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.

_____

_____

4. Has anyone ever filed a claim against you regardless of whether the claim was dismissed or a judgment was rendered? **If yes, please complete a supplemental claims application for each claim.** ☐ Yes ☐ No

If you answer yes to any of questions 5 through 14, please explain on a separate sheet, and provide full documentation from any agency involved.

5. Do you know of any circumstance, act, error or omission that could possibly result in a professional liability claim against you? ☐ Yes ☐ No

6. Do you anticipate any changes in staff or services provided in the next year? ☐ Yes ☐ No

7. Are you in military service or employed full-time by the federal government? ☐ Yes ☐ No

8. Do you treat patients at a correctional facility? ☐ Yes ☐ No

9. Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked? ☐ Yes ☐ No

10. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked? ☐ Yes ☐ No

11. Do you have any condition or engage in any activity, or use any substance(including alcohol, drugs or medications) which affects, impairs or limits your ability to practice dentistry/oral surgery with reasonable skill and safety? ☐ Yes ☐ No

Applicant name_____

12. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? ☐ Yes ☐ No

13. Has your professional liability coverage ever been cancelled, restricted, non renewed, declined or have you withdrawn an application for insurance to avoid declination? ☐ Yes ☐ No

14. Has a complaint against you ever been submitted to the New Jersey State Board of Dentistry or are you currently under investigation by any regulatory authority? ☐ Yes ☐ No

15. Do you provide any services over the internet? ☐ Yes ☐ No
If yes, please explain_____

16. Do you participate as a principal investigator for any clinical trials? ☐ Yes ☐ No
If yes, do you follow FDA-approved protocols? ☐ Yes ☐ No

17. **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 optional waiver applied to your policy? ☐ Yes ☐ No

Section III Required Documentation

1. Claim history reports (loss runs) from all prior insurance carriers
2. Copy of current declarations page from your current insurance carrier
3. Copy of current New Jersey license
4. Curriculum vitae

Section IV Dentists/Oral Surgeons Services

1. Indicate professional liability limits desired
☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000

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

General Dentistry _____ % (Includes simple extractions)

Oral Surgery _____ % If you are a General Dentist, list the oral surgery procedures you perform_____

_____

Orthodontics _____ % Other (specify) _____ %

3. School of Graduation _____ Graduation Date _____ Degree _____

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

5. 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.

6. 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 have privileges at an accredited hospital? ☐ Yes ☐ No
Current certificate of insurance coverage must be provided.

7. Where are procedures on patients administered general anesthesia performed? (Check all that apply)
☐ In hospital ☐ In office ☐ Other _____

8. 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

9. 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

Applicant name_____

10. Do you administer enteral (oral) sedation alone for the purpose of analgesia (diminution or elimination of pain)? ☐ Yes ☐ No

11. If you answered yes to any of questions 4 through 9, do you adhere to the Dental Association Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (October 2003 and any revision thereof)? ☐ Yes ☐ No

12. Do you administer enteral (oral) sedation or combination of inhalation-enteral (oral) sedation only for the purpose of anxiolysis (diminution or elimination of anxiety)? ☐ Yes ☐ No

13. 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

14. Do you perform the surgical placement of dental implants? ☐ Yes ☐ No

15. Do you perform the prosthetic or restorative component of dental implants? ☐ Yes ☐ No

16. Check any professional organization you are a member of
☐ ADA ☐ State ☐ Local ☐ AAOMS ☐ National ☐ Other _____

17. Do you use filling materials or sealers containing sargenti paste? ☐ Yes ☐ No

19. If you perform oral surgery, do you obtain a documented patient consent prior to performing the 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.

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

19. Is coverage desired for your professional entity? ☐ Yes ☐ No

If yes, name of entity_____

Federal Employer Identification Number_____

20. Does your entity employ any physicians, surgeons, podiarists, 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.

Section V 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 applicant _____ Date _____

Print name of applicant _____

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.

Applicant name _____

Supplemental Claims Information

(If more than four (4) claims, please photocopy this page, complete and attach)

Please complete, in chronological order, for any closed, pending or potential claim.

1. Claimant's/plaintiff's name _____
   Date care rendered _____ Date claim reported _____
   Status: ☐ Open ☐ Closed Date closed _____
   If closed, was any indemnity payment or award made? ☐ Yes ☐ No **If yes, amount** _____
   If open, what is the amount of loss reserve or damages sought? _____
   Name of insurance company defending you _____
   Description of claim (include type of treatment, result of treatment, your involvement) _____
   _____
   _____
   _____
   _____
   _____

2. Claimant's/plaintiff's name _____
   Date care rendered _____ Date claim reported _____
   Status: ☐ Open ☐ Closed Date closed _____
   If closed, was any indemnity payment or award made? ☐ Yes ☐ No **If yes, amount** _____
   If open, what is the amount of loss reserve or damages sought? _____
   Name of insurance company defending you _____
   Description of claim (include type of treatment, result of treatment, your involvement) _____
   _____
   _____
   _____
   _____
   _____

3. Claimant's/plaintiff's name _____
   Date care rendered _____ Date claim reported _____
   Status: ☐ Open ☐ Closed Date closed _____
   If closed, was any indemnity payment or award made? ☐ Yes ☐ No **If yes, amount** _____
   If open, what is the amount of loss reserve or damages sought? _____
   Name of insurance company defending you _____
   Description of claim (include type of treatment, result of treatment, your involvement) _____
   _____
   _____
   _____
   _____
   _____

4. Claimant's/plaintiff's name _____
   Date care rendered _____ Date claim reported _____
   Status: ☐ Open ☐ Closed Date closed _____
   If closed, was any indemnity payment or award made? ☐ Yes ☐ No **If yes, amount** _____
   If open, what is the amount of loss reserve or damages sought? _____
   Name of insurance company defending you _____
   Description of claim (include type of treatment, result of treatment, your involvement) _____
   _____
   _____
   _____
   _____
   _____

Applicant 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 _____

_____
Medical Care Practitioner signature

_____
Print name of applicant

_____
Home address*

_____
City, State, Zip*

Home Phone Number*

_____
Witness to Medical Care Practitioner's signature

Date _____

_____
Corporation

_____
Officer signature

_____
Print name of officer

_____
Address of corporation

*This information will only be used for cancellation notification and Extended Reporting offers only.

Appendix A - Staff Schedule

Entity name _____

List all owners, partners, independent contractors, and employees (physicians, chiropractors, dentists, etc.)

Name	Policy #, if Princeton Insured	License #	Specialty or Position	Date of Hire	Avg # of Hrs Per Week

List all allied professionals (RN, LPN, CRNA, Nurse Midwife, Tech, Medical Assistant, Social Worker, Occupational or Physical

Name	Policy #, if Princeton Insured	License #	Specialty or Position	Date of Hire	Avg # of Hrs Per Week

Therapist, Licensed Counselor, Physician Assistant-Surgery or Non-Surgery, etc.)

For all professional staff not insured with Princeton, attach certificates of insurance or a copy of their professional liability policy and claims history for each individual.

Signature_____Date:_____

Name: _____

Appendix B - Organization Application

1. Name of organization _____

   Address _____

   Tax ID# _____

   Effective date _____ Retroactive date _____

   Policy Type: ☐ CM ☐ OCC ☐ OP

2. a) Description of operations performed _____

   b) Description of services performed _____

	Past 12 Months	Projected Next 12 Months
Patient visits (each encounter)	_____	_____
Gross receipts	_____	_____
Payroll	_____	_____
Other	_____	_____

3. Are overnight facilities available? ☐ Yes ☐ No

4. Hours of operation _____

5. Describe the type of organization and ownership. *(Check all that apply)*

_____ Professional Association
_____ Corporation
_____ Joint Venture
_____ For Profit
_____ Other, describe _____

_____ Partnership
_____ Community Clinic (non-profit)
_____ Partnership, Limited
_____ Not for Profit

6. Are there subsidiaries that are to be included in this coverage? ☐ Yes ☐ No
   *(**If yes,** please list name of subsidiary and provide a current organizational chart)*

_____

7. List members, shareholders, etc.

_____

_____

8. How long has the organization been in business? _____ Years _____ Months

9. Does the organization have a written Quality Assurance/Risk Management Program? ☐ Yes ☐ No

10. Has the organization ever been sued regardless of whether the claim was dismissed or a judgment rendered? ☐ Yes ☐ No
    *(**If yes,** please complete supplemental claims information sheet)*

11. Name of current professional liability insurance carrier _____
    (Please attach a copy of the declarations page showing: retro date, limits of liability, policy period and any restrictive endorsements)

12. Has your professional liability insurance ever been cancelled, refused or non-renewed? ☐ Yes ☐ No

13. Are procedures in place for patient transfers to another facility in the event of an emergency? ☐ Yes ☐ No
    *(**If yes,** please describe)*

_____

_____

_____

Name: _____

14. Are medications administered? ☐ Yes ☐ No
If yes, by whom?

_____

15. Do you perform consultations, render medical services, offer medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, telemedicine or internet medicine? ☐ Yes ☐ No
If yes, do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No
If yes, provide details on a separate sheet and attach verification of coverage, if applicable.

16. **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 optional waiver applied to your policy? ☐ Yes ☐ No

Complete Appendix B for each organization named.
Attach copies of all advertising materials, stationary, telephone directory yellow pages, handouts and other advertising.

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 as well as the Company's calculation of the applicable premium should a policy be issued. As a result, I agree to inform the Company of any changes to my practice. I authorize release and exchange of any underwriting or claims information between all prior carriers and Princeton Insurance Company.

Signature:_____ Date:_____

Print Name:_____

Supplemental Questionnaire for Dentists Employing Hygienists Administering Local Anesthesia

Applicant 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