

# Princeton Insurance

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PARTNERSHIP. PREVENTION. PROTECTION.

**Dentist and Oral Surgeon**

**Professional Liability Application**

746 Alexander Road  
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[www.PrincetonInsurance.com](http://www.PrincetonInsurance.com)

# Princeton Insurance

## Dentist and Oral Surgeon Professional Liability Application

PARTNERSHIP. PREVENTION. PROTECTION.

### 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 visits, 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. |  |                  |
|              |          |               |      |  |                  |
|              |          |               |      |  |                  |

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-ental (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, 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.**

**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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 applicant

\_\_\_\_\_  
Officer signature

\_\_\_\_\_  
Home address\*

\_\_\_\_\_  
Print name of officer

\_\_\_\_\_  
City, State, Zip\*                      Home Phone Number\*

\_\_\_\_\_  
Address of corporation

\_\_\_\_\_  
Witness to Medical Care Practitioner's signature

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

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

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: \_\_\_\_\_

Applicant name \_\_\_\_\_

**Appendix B - Organization Application**

1. Name of entity \_\_\_\_\_  
Address \_\_\_\_\_  
Tax ID# \_\_\_\_\_  
Retroactive date \_\_\_\_\_

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 type of entity 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 entity been in business? \_\_\_\_\_ Years \_\_\_\_\_ Months

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

10. Has the entity ever been sued regardless of whether the claim was dismissed on 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.

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

15. **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.**

## 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