



746 Alexander Road  
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## Dentists and Oral Surgeons Professional Liability Application

**Princeton Insurance**  
PARTNERSHIP. PREVENTION. PROTECTION.

(800) 334-0588



## Dentists and Oral Surgeons 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 (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

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.)

### Corporate Coverage

10. Is coverage desired for your professional corporation?  Yes  No

If yes, name of entity: \_\_\_\_\_

Federal Employer Identification Number: \_\_\_\_\_

11. Does your entity have any employees, independent contractors or partners?  Yes  No

*(Employees and independent contractors are defined as 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.)*

**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.

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

### Practice Locations

12. List all locations where you presently work. (Draw a line through any location where you are not practicing, or add additional locations):

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.*

Name: \_\_\_\_\_

13. 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

14. Previous professional liability insurance carrier(s):

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

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

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

17. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage?  Yes  No  
 (If you answered yes to any of questions 15, 16 or 17, please provide full details on a separate sheet.)

18. 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?  Yes  No  
 (If yes, please complete a supplemental claims application for each claim)

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

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

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

Name: \_\_\_\_\_

9. Has your professional license ever been denied, suspended, revoked or voluntarily surrendered or has probation been invoked?  Yes  No
10. 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 medicine with reasonable skill and safety?  Yes  No
11. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act?  Yes  No
12. 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
13. 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
14. Do you provide any services over the internet?  Yes  No  
**If yes, please explain:** \_\_\_\_\_  
**(If you answered yes to any of questions 7 through 14, please explain on a separate sheet, and provide full documentation from any agency involved)**
15. Do you participate as a principal investigator for any clinical trials?  Yes  No  
**If yes, do you follow FDA-approved protocols?**  Yes  No
16. **Optional Waiver of Consent to Settle** *1% discount to premium.* If you chose 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 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)*

6. Where are procedures on patients administered general anesthesia performed?  
*(Check all that apply)*  
 In hospital     In office     Other \_\_\_\_\_
7. 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
8. 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

9. Do you administer enteral (*oral*) sedation alone for the purpose of analgesia  
(*diminution or elimination of pain*)?  Yes  No
10. If you answered yes to any of the questions 4 through 9 above, 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
11. 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
12. 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
13. Do you perform dental implants?  Yes  No  
If yes: 1) Do you perform the surgical placement of the implant?  Yes  No  
2) Do you perform the prosthetic or restorative component?  Yes  No
14. Check any professional organization you are a member of:  
 ADA  State  Local  AAOMS  National  Other \_\_\_\_\_
15. Do you use filling materials or sealers containing sargenti paste?  Yes  No
16. If you perform oral surgery, do you obtain a documented patient consent prior to performing  
the surgery?  Yes  No
17. Do you inject derma fillers?  Yes  No

**Section V Signature**

**This section must be completed by all applicants.**

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 the 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 FRAUD 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.**

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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





**Appendix B - Organization Application**

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

2. a) Description of operations performed \_\_\_\_\_  
 b) Description of services performed \_\_\_\_\_

	<b>Past 12 Months</b>	<b>Projected Next 12 Months</b>
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)*

- |   |  |
|---|--|
| <input type="checkbox"/> Professional Association | <input type="checkbox"/> Partnership                   |
| <input type="checkbox"/> Corporation              | <input type="checkbox"/> Community Clinic (non-profit) |
| <input type="checkbox"/> Joint Venture            | <input type="checkbox"/> Partnership, Limited          |
| <input type="checkbox"/> For Profit               | <input type="checkbox"/> Not for Profit                |
| <input type="checkbox"/> Other, describe _____    |  |

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 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 chose 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.**