NEW _____

RENEWAL OF POLICY NUMBER _____

ADD'L DENTIST TO POLICY NUMBER _____

DENTIST'S
PROFESSIONAL LIABILITY APPLICATION

THE CINCINNATI INSURANCE COMPANIES

☐ The Cincinnati Insurance Company
☐ The Cincinnati Casualty Company
☐ The Cincinnati Indemnity Company

SECTION I - GENERAL INFORMATION

1. How is the policy named insured to read? _____

   Is this an individual ☐partnership ☐corporation ☐LLCLLP ☐other: _____

2. Mailing Address: _____

   _____

   Office Address: _____ Phone Number: ( ) _____

   Website: _____

SECTION II - CLAIMS INFORMATION

Please fully explain any "Yes" answers to the following questions in the space provided for "Remarks".

	Yes	No
1. Have you or any of your employees had a claim made or suit brought for actual or alleged malpractice, error or mistake in the past five years?	☐	☒
2. During the past five years, has any insurer cancelled any similar insurance issued to you or declined to issue such insurance? (N/A in MO)	☐	☒

SECTION III - DENTIST INFORMATION - SEPARATE APPLICATION TO BE COMPLETED BY EACH DENTIST

1. Name of applicant: _____
2. If employed, by whom and in what capacity? _____
3. List university or college from which you graduated: _____

   Degree: _____ Year: _____ Date of first year entering licensed dental practice: _____
4. State(s) you are licensed in: _____
5. State(s) that you practice in: (IN only Professional License No. _____) _____
6. Are you a specialist? ☐ Yes ☐ No If "Yes", please describe: _____

   School certified by: _____ Date certified: _____
7. Do you meet the continuing education requirements of your state? ☐ Yes ☐ No If "No", please explain in the space provided for "Remarks".
8. How many total hours per week at all locations, do you practice? _____

SECTION IV - COVERAGE INFORMATION

1. Effective dates: From: _____ To: _____
2. Please indicate limits of insurance by checking appropriate option:

   ☐ A $100,000/300,000
   ☐ B $200,000/600,000
   ☐ C $300,000/900,000
   ☐ D $500,000/500,000
   ☐ E $500,000/1,000,000
   ☐ F $1,000,000/1,000,000
   ☒ G $1,000,000/2,000,000
   ☐ H $1,000,000/3,000,000
   ☐ I $2,000,000/4,000,000
   ☐ J $2,000,000/6,000,000

   Indiana License/Location: If Multi-Jurisdiction Endorsement is to apply, please complete the following:

   "Designated Jurisdiction" Limits*: n/a Each Dental Incident Limit n/a Aggregate Limit

   "Any Other Jurisdiction" Limits: n/a Each Dental Incident Limit n/a Aggregate Limit

   *Jurisdiction subject to Patient's Compensation Fund, which limits applicant's financial liability.
3. Please indicate if umbrella coverage is desired: ☐ Yes ☐ No If "Yes", please complete an umbrella application.
4. Is your expiring policy a "claims-made" policy? ☐ Yes ☐ No If "Yes", prior acts coverage may be needed.
5. a. Do you desire prior acts coverage? ☐ Yes ☐ No If "Yes", please complete SECTION **VII**.

   b. If "No", have you purchased an extended reporting period endorsement from your prior carrier?

   ☐ Yes ☐ No

SECTION V - PRACTICE INFORMATION

1. **Please fully explain any "Yes" answers to the following in the space provided for "Remarks":**

	Yes	No
a. Has any dental or state licensing authority ever revoked, suspended or imposed any restrictions on your license, disciplined you, reprimanded you or placed you on probation?	☐	☒
b. Do you have any current hospital staff appointments or privileges? If "Yes", please forward a copy of your Delineation of Privileges form.	☐	☒
c. Have you had hospital privileges granted, denied or revised?	☐	☒
d. Has your membership in a dental association ever been revoked or suspended?	☐	☒
e. Do you perform any procedures which have been introduced to the practice of dentistry within the last two years?	☐	☒
f. Have you ever had a case brought against you in peer review?	☐	☒
g. Have you ever voluntarily surrendered or had a DEA license refused, suspended or revoked?	☐	☒

2. Does your office comply with OSHA and ADA guidelines for infection control?
   ☐ Yes ☐ No If "No", please explain in space provided for "Remarks".
   a. Do you autoclave or heat sterilize equipment after each patient? ☒ Yes ☐ No If "No", explain in space provided for "Remarks".
   b. Do you wear surgical gloves, mask, gown and protective eyewear for all patient care? ☒ Yes ☐ No If "No", explain in space provided for "Remarks".
3. Are you a member of a local, state or national dental association? ☒ Yes ☐ No
   If "Yes", please list name of the association: _____
4. a. Dentist procedure checklist. Please indicate the procedures you perform.
   General Dentistry.
   _____ % Endodontics
   Do you treat multi-rooted teeth? ☐ Yes ☐ No
   Do you use Sargenti paste/cement? ☐ Yes ☐ No
   _____ % Pedodontics
   _____ % Orthodontics **Check Appropriate Procedures/Cases Treated**
   _____ % Periodontics: _____Gingivitis _____Slight Periodontitis _____Moderate Periodontitis
   _____Osseous Surgery _____Advanced Periodontitis
   _____Refractory Progressive Periodontitis
   _____ % Prosthodontics: _____Removable _____ Fixed
   _____ % Surgery: _____Orthognathic Surgery _____ Reducing Fractures
   _____ Traumatic Surgery - please explain on the last page.
   _____Other - Please describe in space provided for "Remarks".
   _____ % General Dentistry (including simple extractions, but not procedures listed above)
   _____ % Oral Surgery or other, please describe (print or type): _____

   b. 1. Do you extract third molars? If yes, ☐ Yes ☐ No
   (a) Erupted ☐ Yes ☐ No
   (b) Impacted, soft tissue or partial bony ☐ Yes ☐ No
   (c) Impacted, full bony ☐ Yes ☐ No
   2. Do you perform oral cancer examinations? ☐ Yes ☐ No
5. Check the following additional dental techniques or procedures you perform:
   a. Prosthetic implants Yes No If "Yes", please describe in space provided for "Remarks".
   b. Mini or immediate load implants Yes No If "Yes", please describe in space provided for "Remarks".
   c. Temporary Anchorage Devices (TAD) or micro implants ☐ Yes ☐ No If "Yes", please describe in space provided for "Remarks".
   d. Surgical implants ☐ Yes ☐ No If "Yes", complete Section **VIII.**
   e. Treatment of Temporomandibular Joint (TMJ) disorders ☐ Yes ☐ No If "Yes", please describe in space provided for "Remarks".
6. a. Do you utilize professional independent contractors in your practice? ☐ Yes ☐ No
   If "Yes", please explain your working relationship in the "Remarks" section of this application.
   If "Yes", a certificate of insurance with a minimum limit of $1,000,000 is required from the independent contractor.
   b. Does the independent contractor perform procedures beyond the scope that you perform? ☐ Yes ☐ No
   If "Yes", please explain in the "Remarks" section of this application.
   c. How many professional independent contractors do you utilize? _____

SECTION V - PRACTICE INFORMATION (CONT'D)

7. Which of the following procedures do you perform?
   a. Botulinum toxins, dermal fillers, and/or other dermal procedures (including hyaluronic acid products, collagen injections, dermabrasions, etc.) ☐ Yes ☐ No If "Yes", please provide a copy of the proper training course certificate of completion. Also, provide a copy of the waiver/informed consent form used with your patients.
   b. Sleep Apnea Therapy ☐ Yes ☐ No If "Yes", please indicate the following: ☐ I treat only after referral from a physician. ☐ I treat without a physician referral.
8. Number of professional employees in the following categories:
   _____Hygienists _____Dental Assistants _____E.F.D.A.s _____Anesthesiologists/Anesthetists
   _____Others, please describe: _____
   _____Dental Therapist/Advanced Therapist
   _____Dentists (attach separate application for each)

SECTION VI - ANESTHETIC AND OTHER INFORMATION

1. Do you utilize any of the following anesthesia?
   a. Local anesthesia or inhalation sedation (N_2O)..... ☐ Yes ☐ No
   b. Oral sedation..... ☐ Yes ☐ No
   c. Intravenous conscious sedation (IV) ..... ☐ Yes ☐ No
   d. Intramuscular sedation *(IM) ..... ☐ Yes ☐ No
   e. General anesthesia* (includes deep sedation) ..... ☐ Yes ☐ No
   *If "Yes", is IM or general anesthesia administered in the hospital only? ☐Yes ☐ No
   Do you, an employee of yours or a trained anesthetist administer the general anesthesia or intramuscular sedation? ☐ Self, Employee ☐ Anesthetist - Independent Contractor (Please obtain certificate of insurance)
2. Describe IV training and courses taken: _____
3. Do you consult with the patient's primary care physician on underlying health conditions; i.e., diabetes, heart, existing infections, etc.? ☐ Yes ☐ No
   If "No", please explain in space provided for "Remarks.
4. Do you obtain a complete medical history on all patients? ☐ Yes ☐ No How often is the information updated? _____
   If "No", please explain in space provided for "Remarks".
5. Do you obtain a patient "informed consent" form? ☐ Yes ☐ No If "Yes", explain on last page the procedures for which you obtain the form.
   If "No", please explain in space provided for "Remarks".

SECTION VII - PRIOR ACTS COVERAGE: COMPLETE THIS SECTION ONLY IF YOU ANSWERED "YES" TO SECTION IV, No. 5.

If you are applying for prior acts coverage, please answer the following questions.

1. History of Professional Insurance - Complete the following for the last five-year period:
   Professional Coverage - Primary and Umbrella (Excess)

Policy Term	Name of Carrier	Limit Each Claim/Agg.	Claims-Made	Retro Date

2. Do you know of any circumstances, acts, errors or omissions which could result in a professional liability claim? ☐ Yes ☒ No If "Yes", describe fully in space provided for "Remarks", and indicate if prior carriers have been notified.
3. Prior acts coverage to be effective - From: _____ (retroactive date)
4. Please indicate the limits of insurance requested for the prior acts period.
   Each Incident $ _____ Aggregate $_____

SECTION VIII - IMPLANT INFORMATION - COMPLETE IF PERFORMING SURGICAL PLACEMENT OF IMPLANTS

1. Describe the formal training you have received in implantology. Attach description of courses you attended, dates the courses were held and name and location of teaching entity. Include a list of continuing education courses you have attended in the past two years.
2. Has your training in implantology been classroom, hands-on or both?
3. When did you first start placing implants?
4. Attach copies of the informed consent form and patient education material you utilize prior to placing implants.
5. What criteria do you use in selecting patients for implants?

SECTION IX - SUPPLEMENTAL INFORMATION

CLAIM INFORMATION

1. Name of patient/claimant: n/a 2. Date of treatment to allegation

3. Allegation:

4. Date of claim/suit 5. Additional defendants

5.a. Claim reported to prior carrier ☐ Yes ☐ No

5.b. Name of insurer

6. Current disposition: open Amount of reserve $

closed Amount of settlement or judgment $

If no payment, was claim/suit withdrawn ☐ Yes ☐ No

Please provide a narrative description of the case, including nature of treatment, your involvement, etc.

Remarks

Section Number / Question Number Explanation

NOTE TO APPLICANT: PLEASE READ CAREFULLY

You agree that signing this application does not bind The Company to provide the insurance; however, this application will be the basis of the contract should a policy be issued. You certify that reasonable inquiry has been made to obtain the answers given in the application and that this application has been completed in a true, correct and complete manner to the best of your knowledge and belief. You also certify that you are duly registered and licensed to practice your profession under the laws of all jurisdictions of which you practice.

Applicant's Signature **Date**

Agent's Signature **Date**

Agency and Code Number

RiskPoint Insurance Advisors, LLC

Agent's Name and License Number (Florida only)

Refer to the following page for the current version of ACORD 63 FRAUD STATEMENTS.

AGENCY CUSTOMER ID: _____

FRAUD STATEMENTS

AGENCY		CARRIER	NAIC CODE
POLICY NUMBER	EFFECTIVE DATE	APPLICANT / NAMED INSURED	

Applicable in AL, AR, DC, LA, MD, NM, RI and WV
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.

Applicable in KS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA
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* (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

_____ _____
APPLICANT'S SIGNATURE DATE (MM/DD/YYYY)