



180 Park Ave, Floor 1
Florham Park, NJ 07932
Phone: Aric Longo (973)315-0708

**DENTAL PROFESSIONAL LIABILITY
PREMIUM INDICATION FORM**

Full Name: _____
City/State/Zip: _____
E-mail: _____ Phone () _____
Degree: _____ Specialty: _____

INFORMATION REGARDING COVERAGE

Requested Effective date: _____ Prior Acts/Retro Date (if applicable) _____
Desired Limits of Liability: _____
Type of policy (check one): claims made (with prior acts) claims made (without prior acts) occurrence
Have you ever been cancelled/non-renewed or declined malpractice coverage: yes no
If yes, please briefly explain: _____

INFORMATION REGARDING YOU AND YOUR PRACTICE

Year Graduated: _____ Are you entering private practice for the first time? yes no
How many hours per week are you involved in the practice of dentistry: _____
Will you be requesting separate entity coverage as well? yes no *if yes, name legal entity: _____
Provide the percentage of your practice that fall into these categories (must equal 100%)
 ___ endodontics ___ orthodontics ___ oral surgery (simple extractions)
 ___ general dentistry ___ periodontics ___ pediatric dentistry
 ___ oral pathology ___ prosthodontics
Do you perform extractions of bony impacted or partially bony impacted teeth?: yes no *(if yes, what % ___)
Do you perform any surgical placement of implants: yes no *(if yes, what % ___)
Do you provide any cosmetic facial services including Botox injections/liposuction/face lifts: yes no
Do you perform extensive cosmetic full mouth restorations? yes no
Do you administer IV/IM Sedation or General Anesthesia: yes no
Is your practice limited to the use of local anesthesia and N2O?: yes no
Do you perform Oral Moderate Conscious Sedation (sedation dentistry)? yes no
Would you like Consent to Settle on your policy? yes no *If you select no, a 10% discount will be applied
Are you a member of either the ADA or AGD? (If yes, please circle which below)
 AAPD ADA AGD Member AGD Fellowship AGD Mastership
How many consecutive years claims free are you? _____
Have you been involved in any claim, suit or disciplinary action by the state dental board in the last
10 years?: yes no *If yes, how many claims: _____ *If yes, is/are claim(s) still open?: yes no
Please provide paid indemnity amount(s): _____
If you had claims, please provide the date the claim(s) were closed: _____