APPLICATION FOR STANDARD DENTISTS PROFESSIONAL LIABILITY INSURANCE

Administered by:
Innovation Growth Partners Specialty, LLC
100 Glen Eagles Court
Carrollton, GA 30117 | 855-874-1045

Underwritten by:
☐ Great Divide Insurance Company
☐ Nautilus Insurance Company (AZ)

THIS APPLICATION WILL BE ATTACHED TO AND BECOME PART OF THE POLICY

NOTICE: THERE MAY BE BOTH OCCURRENCE AND CLAIMS MADE COVERAGES IN THIS POLICY. CLAIMS MADE COVERAGE IS LIMITED TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED AND REPORTED IN WRITING TO US DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

APPLICANT INFORMATION

1. Full name of Applicant

First Name _____ Middle Initial _____ Last Name _____ Suffix _____ Degree _____ Date of Birth ____/____/____

Mailing Address

Street _____ City _____ County _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____ **Personal** E-Mail Address _____

REQUESTED COVERAGE

2. Practice Information

a. I am a **DENTIST** operating as a(n):
☐ Individual (Solo Practitioner) ☐ Limited Liability Company/Partnership
☐ Employee of a Dental Clinic/Practice ☐ Corporation
☐ Independent Contractor ☐ Professional Association

b. Please provide full legal name of entity above _____

c. If you provide services, under a DBA, please provide name of DBA _____

3. Requested Effective Date ____/____/____

4. Coverage Form Requested ☐ Occurrence ☐ Claims Made

If Claims Made, what is the requested Retro Date: ____/____/____

5. Indicate Limits of Liability for which you are applying (Some limits may not be available in all states)

LIMITS OF INSURANCE - EACH DENTAL INCIDENT/AGGREGATE

☐ $100,000/$300,000 (**LA** PCF only) ☐ $200,000/$600,000 ☐ $500,000/$1,500,000
☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ $400,000/$1,200,000 (**IN** PCF only)
☐ $2,300,000/$6,900,000 (**VA** only) {VA increases each year effective July 1st by 50,000/150,000 until 2031 per VA regulation}

6. Do you require a separate limit of liability for your corporation/partnership? *a 10% premium charge will apply* ☐ Yes ☐ No

7. If prior Professional Liability insurance was on a Claims-Made basis, enter Retroactive Date of that coverage ____/____/____
(date you were first insured under a Claims-Made policy) **ATTACH A COPY OF YOUR CURRENT DECLARATIONS PAGE**

PRACTICE INFORMATION

8. Practice Locations and Characteristics

Primary Practice Information - Location #1: (Where you spend the majority of your time treating patients)

Name of Facility _____

Street _____ City _____ County _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____ E-Mail Address _____

9. Do you share or lease office space with another independently practicing Dentist? ☐ Yes ☐ No
(not as an employee, employer or independent contractor)

a. If yes, is your practice identifiable as a independent practice to your patients? ☐ Yes ☐ No
(including but not limited to: separate entity, billing, signage, website, phone greeting, etc.)

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10. **Number of Dentists (applying for coverage) practicing at all facilities:** _____

Please provide the following for each **dentist** you employ or that provides services on your behalf at **all facilities**.

First Name	Middle Initial	Last Name	Suffix	Speciality	Retroactive Date mm/dd/yyyy	Hours worked **annually**	Employee	Independent Contractor	Owner / Partner
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

11. **Do all Dentists within this group holding PL coverage independent of this application, have limits of liability equal to or greater than the coverage being applied for herein?** ☐ Yes ☐ No

12. **Do you practice at any other locations?** ☐ Yes ☐ No

Primary Practice Information - Location #1:

Name of Facility _____

Street _____ City _____ County _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____ E-Mail Address _____

PRACTICE CHARACTERISTICS AND LICENSURE

13. **Are you an Oral and Maxillofacial Surgeon *OR* a Dentist Anesthesiologist?** ☐ Yes ☐ No

14. **Are you an Endodontist, Public Health Dentist, Pediatric Dentist, or Oral Pathologist?** ☐ Yes ☐ No

15. **Do you or any of the Dentists within this group provide or plan to provide services to any patients imprisoned in any local, state or federal correctional facilities or brought to your place of business at any time in the next 12 months?** ☐ Yes ☐ No

16. **What percentage of your Practice involves:**

_____ % IV/IM sub-cutaneous conscious Sedation adminstered by YOU **prior** to your patient treatment

_____ % IV/IM sedation to an unconscious state or general anesthesia, administered by YOU prior to your patient treatment

17. **If you are a Periodontist, Orthodontist, or Prosthodontist, what percentage of your practice involves simple extractions or surgical placement of implants?** _____ %

18. **If you are a General Dentist, what percentage of your practice involves:**

_____ % Implant restorations

_____ % Endodontia

_____ % Surgical Periodontal Procedures

_____ % Prosthodontics

_____ % Periodontia

_____ % Simple Extractions (no bony or partial bony impacted teeth)

19. **What percentage of your practice involves extractions of full or partial bony impacted teeth and/or surgical placement of implants?** _____ %

20. **When did you receive your license to practice dentistry? Please enter month/year:** _____/_____

21. **Do you hold a certificate of Anesthesia issued by the Kansas Board of Healing Arts?** ☐ Yes ☐ No

22. **Do you use the Sargenti Technique using N2 Universal?** ☐ Yes ☐ No

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23. **Employment Status:** Number of hours worked **annually:** _____

24. **Risk Management:** Have you completed risk management courses in the past 3 years? ☐ Yes ☐ No

25. **Have you ever reported a claim with your insurance carrier?** ☐ Yes ☐ No

a. If Yes, please indicate month/year that the most recent claim was reported: _____/_____

26. **Do you require coverage for any Additional Insureds?** ☐ Yes ☐ No
List only those for which you are contractually obligated to provide coverage

☐ Landlord *5% premium charge will apply* ☐ All Other *10% premium charge per Additional Insured will apply*

Name of Additional Insured Landlord: _____

Name of other Additional Insured: _____

Name of other Additional Insured: _____

27. **Do you require coverage for Medical Waste?** ☐ Yes ☐ No
An additional premium charge of $75.00 will apply

Limits of Liability $50,000 each claim $50,000 aggregate

28. **Do you require coverage for Enhanced Information and Network Security?** ☐ Yes ☐ No
An additional premium charge of $100.00 will apply

Supplementary Coverages	**Limits of Liability**	
a. Information and Network Security	$25,000 each claim	$25,000 aggregate
b. Media Liability	$25,000 each claim	$25,000 aggregate
c. Regulatory Privacy Proceeding and Regulatory Fines and Penalties	$25,000 each claim	$25,000 aggregate
d. Customer Notification and Credit Monitoring Expense	$10,000 each claim	$10,000 aggregate
e. Electronic Data Recovery and Replacement Expenses	$10,000 each claim	$10,000 aggregate

29. **DENTAL SCHOOL FACULTY**

Are you are a faculty member of a duly accredited Dental School? ☐ Yes ☐ No

Name of Dental School _____ Phone Number _____

On faculty since _____ Position/Department _____

Appointment Status ☐ Full-Time: 32 hours or greater ☐ Half-Time: 16-31 hours ☐ Part-Time: 15 hours or less

INSURANCE HISTORY

30. **Insurance Coverage Summary For The Past Four (4) Years**

Insurer	Policy Number	Policy Term	Limits	Premium	Claims-Made / Occurrence
		____/____/____	____/____		
		____/____/____	____/____		
		____/____/____	____/____		
		____/____/____	____/____		

31. **CLAIM/INCIDENT HISTORY**

a. Have you ever had a malpractice claim or suit filed against you or any members of your corporation/partnership/association? ☐ Yes ☐ No

b. Do you know of any incident which may result in a claim against you or any members of your corporation/partnership/association? ☐ Yes ☐ No

c. Has any insurance company ever declined coverage, refused to renew, conditionally renewed or canceled a professional liability policy covering you or any members of your corporation/partnership/association? ☐ Yes ☐ No

Month/Year coverage declined, refused to renew, conditionally renewed or canceled _____/_____

Please select reason for declined coverage, refused to renew, conditionally renewed or canceled:

☐ I didn't pay my premium
☐ I had a claim
☐ I no longer qualified for insurance because of my specialty
☐ I no longer qualified for insurance due to the procedures I perform
☐ I was convicted of a crime
☐ I worked for a group whose insurance was cancelled
☐ My state board took action against my license
☐ The company I was with is no longer insuring dentists

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32. DISCIPLINARY ACTIONS

a.	Have you, or any member of your corporation/partnership/association, ever been the subject of an investigatory or disciplinary proceeding or review?	☐ Yes	☐ No
b.	Have you, or any member of your corporation/partnership/association, ever been convicted of a felony (other than a minor traffic offense), or do you have any criminal charges pending against you?	☐ Yes	☐ No
c.	Have you, or any member of your corporation/partnership/association, ever been treated for alcohol, drug, or other substance abuse?	☐ Yes	☐ No
d.	Have you, or any member of your corporation/partnership/association, ever had your dental license or license to prescribe drugs suspended or revoked?	☐ Yes	☐ No

IF YOU ANSWERED YES TO QUESTIONS 31a, 31b or 31c
COMPLETE A SUPPLEMENTAL CLAIM INFORMATION FORM FOR EACH CLAIM, SUIT, INCIDENT OR DISCIPLINARY ACTION.

REPRESENTATIONS

By signing this application you, the applicant, agree with us, the Company, that:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have divulged any and all such situations in Question 22 of this application; and
2. The application and attachments, and all of the statements and answers given therein are;
   a. accurate and complete to the best of your knowledge;
   b. a material inducement to us to provide a proposal for insurance and any policy issued by us is issued in specific reliance upon these representations;
   c. and representations you are making on behalf of all persons and entities proposed to be covered;
3. You agree to report to us in writing any material change in your operations, conditions, or answers provided in this application that may occur or be discovered after the completion date of the application and before the effective date of the policy. On receipt of such written notice, we have the right to modify or withdraw any proposal for insurance we have offered, at our sole discretion
4. You authorize us, our agents and representatives to secure claims information from your current and previous insurance carriers.
5. The discovery of any fraud, intentional concealment, or misrepresentation of material fact will render this Policy, if issued, void at inception.
6. You, and all members of your corporation/partnership/association, are licensed in all states in which professional services are provided

GENERAL FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and civil penalties.

SIGNATURE

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 the person to criminal and [NY: substantial] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

Signature of Applicant _____ Date _____

Signing of the application does not bind you or us.

APPLICATION MUST BE SIGNED AND ATTACHED TO THE POLICY

PLEASE CONFIRM THE FOLLOWING ITEMS ARE INCLUDED (if applicable)

- ☐ If you currently have claims made coverage, a copy of your current declarations page
- ☐ If you have a claim/loss, a copy of a current loss run, dated within 90 days, from your current insurance carrier
- ☐ If you have a Board Complaint made against you, a copy of all correspondence, orders, and stipulations
- ☐ If you have a claim, please complete the Dentist Supplemental Claim Form for each claim

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DENTIST SUPPLEMENTAL CLAIM INFORMATION

1. Full name of Applicant

First Name _____ Middle Initial _____ Last Name _____ Suffix _____ Degree _____

2. Date of Actual or Alleged Incident: _____/_____

3. Was incident reported to your insurance carrier? ☐ Yes ☐ No

If yes, please submit a copy of report as submitted to your insurance carrier

Narrative Description of Incident. Describe the type of treatment rendered, as well as the injuries for which the claim was made. If the claim was not made by a patient, describe how it arose.

4. List any other parties, institutions or hospitals involved as codefendants.

5. Name of the insurance company defending you, if applicable:

Current Status of the Claim/Suit
☐ Formal suit actually brought against you ☐ Incident only (Suit merely threatened)
☐ Request for records ☐ Complaint made to Licensing Board

Disposition of Claim
☐ Claim pending ☐ Claim Closed
☐ Payment made on my behalf ☐ Payment NOT made on my behalf

What have you done to prevent a similar incident or claim from happening again?

If not already described above, please describe any other incidents or adverse results that may develop into future claims or suits, including licensing board or peer review committee proceedings.

Signing this form indicates that the information provided above is true to the best of your knowledge and belief.

Signature of Applicant _____ Date _____

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ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, RHODE ISLAND, WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

COLORADO APPLICANTS: 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 FOR INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

KANSAS APPLICANTS: 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 AND MAY BE SUBJECT TO CRIMINAL AND/OR CIVIL FINES OR PENALTIES.

KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

MAINE, TENNESSEE, VIRGINIA, WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO 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.

MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES.

PENNSYLVANIA APPLICANTS: 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.

VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.