Dentists Liability Application

AMERICAN CASUALTY COMPANY OF READING, PA
151 N. Franklin, Chicago, IL 60606

NOTICE: THERE MAY BE BOTH OCCURRENCE COVERAGES 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.

A. GENERAL INFORMATION

Please type or print. EVERY ITEM MUST BE COMPLETED. If not applicable, write N/A. If additional space is required, please provide your answers on a copy of your practice letterhead.

1. ______________________ FIRST NAME ______ M ______________________ LAST NAME DDS ☐ DMD ☐

Mailing Address:

__________ STREET __________ CITY __________ COUNTY __________ STATE __________ ZIP

Practice addresses and percentage at each address (total percentage must equal 100%)

Primary: __________ STREET __________ CITY __________ COUNTY __________ STATE __________ ZIP ______ %

Primary: __________ STREET __________ CITY __________ COUNTY __________ STATE __________ ZIP ______ %

2. Contact Information:

a. __________ BUSINESS PHONE NUMBER **b.** __________ CELL PHONE NUMBER **c.** __________ E-MAIL ADDRESS

d. __________ WEB PAGE URL

B. COVERAGE INFORMATION

1. Are you entering practice for the first time? ☐ Yes ☐ No

2. Requested Policy Effective Date: __________ MM / DD / YYYY

3. ☐ Claims Made Coverage **or** ☐ Occurrence Coverage

3a. If Claims Made Coverage: Please include a copy of your current Declarations Page AND provide retroactive date: __________ MM / DD / YYYY

3b. Date of Birth: __________ MM / DD / YYYY

4. Coverage Options: Please check the coverage Options and Limits you desire:

☐ **Option 1 Dental Professional Liability Only**

☐ **Option 2 Dental Professional Liability and Business Liability Coverages** including General Liability, Employee Benefits Liability, Employment Practices Liability*, Hired/Non-Owned Automobile Liability and Medical Waste Legal Expense Reimbursement (*Employment Practices Liability: $5,000 limit may be increased.) Please check with your agent for a quote.

☐ **Business Owners', Cyber Liability and Workers Compensation coverage can also be purchased. Please send me information.**

© CNA All Rights Reserved.

DENTAL PROFESSIONAL LIABILITY LIMITS

☐ $1,000,000/$3,000,000

☐ $1,300,000/$3,900,000 (NY Only) ☐ $2,000,000/$6,000,000 ☐ $3,000,000/$6,000,000

☐ $4,000,000/$6,000,000 ☐ $5,000,000/$6,000,000

Please check desired limit option above. NOTE: All limit options may not be available in all states.

5. List prior insurance carrier(s) for the past three (3) years. If none, state "None."

Name of Insurance Carrier	Effective Date	Expiration Date	Coverage Type	Limits of Liability
			☐ Claims-made ☐ Occurrence	
			☐ Claims-made ☐ Occurrence	
			☐ Claims-made ☐ Occurrence	

5b. Please explain any gaps in your insurance history: ______

6. Will you be providing dental services for which coverage is provided by another Professional Liability policy? . . . . ☐ Yes ☐ No

If "Yes", please explain: ______

7. Are you now practicing, or have you ever practiced, without Professional Liability insurance . . . . ☐ Yes ☐ No

If "Yes", please explain: ______

8. List all states where you hold, or have held, a Dental License even if the license is not currently active. (attach a separate sheet if needed)

State ______ License Number ______ Status of License (e.g., active, inactive, pending, etc.) ______

9. Consent Waiver **(May not be available in all states)**: Do you wish to waive the provision in the policy requiring us to obtain your consent in order to settle a claim against you? (Note: A premium credit may apply. Not available in all states.) . . . . ☐ Yes ☐ No

C. EDUCATION

1. Are you a General Dentist? . . . . ☐ Yes ☐ No

2. Are you a specialist? . . . . ☐ Yes ☐ No
If so indicate below:

☐ Periodontist ☐ Prosthodontist ☐ Endodontist
☐ Pediatric Dentist ☐ Orthodontist ☐ Oral Pathologist
☐ Oral Surgeon ☐ Public Health Dentist ☐ Oral Radiologist
☐ Fulltime Faculty non-intramural

3. Are you a current member of the AGD? . . . . ☐ Yes ☐ No

a. If Yes, AGD Membership Number ______
b. AGD Fellowship? . . . . ☐ Yes ☐ No
c. AGD Mastership? . . . . ☐ Yes ☐ No

4. Are you a member of any dental organization(s)? . . . . . ☐ Yes ☐ No
If "Yes" please provide the name(s) of the organization(s):

______

______

5. List your training and education.
(If more space is required, use a sheet of practice letterhead).

a. ______ U.S. DENTAL SCHOOL/DEGREE ______ DATE COMPLETED

______ CITY ______ STATE ______ COUNTRY

b. ______ PROGRAM

c. Are you a Foreign Dental School Graduate? . . . . ☐ Yes ☐ No

______ NAME OF FOREIGN DENTAL SCHOOL ______ DATE COMPLETED

______ COUNTRY ______ PROFESSIONAL DEGREE

d. ______ RESIDENCY LOCATION ______ DATE COMPLETED

e. ______ POST GRADUATE CERTIFICATION

f. ______ SPECIALTY

g. ______ SPECIALTY LICENSE # (IF APPLICABLE) ______ DATE COMPLETED

6. Board Certification: In what area(s) if any are you Board Certified?

______ BOARD CERTIFIED DATE: ______ MM / DD / YYYY ☐ N/A

7. Drug License: ______ DEA NUMBER

© CNA All Rights Reserved.

D. YOUR PRACTICE

1. A. Name of your legal entity (if any): ____________________

B. Is the sole function / purpose of this entity for the practice of dentistry? ☐ Yes ☐ No

If "No", please provide details (attach a separate sheet if necessary): ____________________

C. If you have a legal entity, do you desire shared or separate limits of liability to apply to your legal entity?

☐ Shared (limits are shared with you at no cost)

☐ Separate (entity has its own set of limits and an additional charge applies)

D. Excluding yourself, name all officers or partners of your legal entity **:

____

2. IF you own your own practice, please provide the number of the following who work for or with you (If none, please write "none" or "0"):

A. Employee dentists (other than yourself and/or partners/corporate officers) ** ________

B. Independent contractor dentists ** ________

C. All other employees (hygienists, assistants, technicians, clerical, etc.) ________

** NOTE: For all employee dentists, independent contractor dentists, and/or other officers or partners of your legal entity, a separate application OR proof of current Professional Liability coverage must be attached for each.

3. Not including practice partners, employees and independent contracting dentists as indicated above, are you in a space-sharing arrangement or agreement with another Dentist, Oral Surgeon, or other Healthcare Provider? ☐ Yes ☐ No

If "Yes", please provide the following:

A. Name(s) and specialty of those with whom you are space-sharing:

Name ____________________ Specialty ____________________

Name ____________________ Specialty ____________________

B. Please attach proof of current Professional Liability insurance for each individual listed in section A. above.

C. Are patient charts for all space-sharing individuals kept in or retrieved from the same area? ☐ Yes ☐ No

4. Do you now, OR have you within the past 5 years, provided professional services in a setting other than your office? (i.e., spa; residence; school; jail; prison; correctional facility; detention center; halfway house or similar type of facility for adults and/or juveniles; etc.) ☐ Yes ☐ No

If "Yes", provide a summary of activities and total number of hours per month: ____________________

____

____

____

5. Please provide patient makeup in the following categories. Please indicate "0" or "N/A" if none:

Direct pay by patient and/or fee for service: ________% Medicaid** patients: ________%

Managed care HMO / PPO / IPA: ________% Other:________% Please describe: ____________________

****If** your practice (or the practice you work for) is currently reimbursed for providing services to Medicaid patients, please provide the following:

A. Number of adult Medicaid patients you see per year: ________ Number of pediatric Medicaid patient visits per year ________

B. Is the practice owned by a private equity group or is it a subsidiary of another practice? ☐ Yes ☐ No

IF "Yes", please provide the name of the entity/entities: ____________________

C. Do you provide treatment to Pediatric Medicaid patients in a mobile dental office or school? ☐ Yes ☐ No

IF "Yes", please provide details as to procedures provided: ____________________

© CNA All Rights Reserved.