

SERFF Tracking Number: CNNA-125312421 State: Arkansas
Filing Company: The Cincinnati Insurance Company State Tracking Number: AR-PC-07-026320
Company Tracking Number: CPRO-07-6008-AR
TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0018 Premises & Operations (OL&T and M&C)
Product Name: CPRO-07-6008-AR
Project Name/Number: /

Filing at a Glance

Company: The Cincinnati Insurance Company

Product Name: CPRO-07-6008-AR

SERFF Tr Num: CNNA-125312421 State: Arkansas

TOI: 17.0 Other Liability - Claims
Made/Occurrence

SERFF Status: Closed

State Tr Num: AR-PC-07-026320

Sub-TOI: 17.0018 Premises & Operations
(OL&T and M&C)

Co Tr Num: CPRO-07-6008-AR

State Status:

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi, Edith
Roberts, Brittany Yielding

Author: Sharon Grubbs

Disposition Date: 10/10/2007

Date Submitted: 10/03/2007

Disposition Status: Approved

Effective Date Requested (New): 05/01/2008

Effective Date (New):

Effective Date Requested (Renewal):

Effective Date (Renewal):

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 10/10/2007

State Status Changed: 10/04/2007

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

At this time, we wish to file form(s) per the attached memorandum.

Final copies are attached for your review.

The corresponding rule(s) filing is being submitted under separate transmittal #CPRO-07-6009-AR.

Filing fees will be sent through the Electronic Filing Fee System as a (EFT) filing.

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Please be advised that we work on a 90-days-in-advance schedule. As a result, we would appreciate your approval by February 1, 2008, for the software to be mailed to our agents on March 1, 2008, for the effective date of May 1, 2008.

Your approval is respectfully requested for use on policies effective on or after May 1, 2008.

Company and Contact

Filing Contact Information

Sharon Grubbs, Senior Filings Analyst sharon_grubbs@cinfin.com
 6200 S. Gilmore Road (513) 870-2091 [Phone]
 Fairfield, OH 45014 ()-[FAX]

Filing Company Information

The Cincinnati Insurance Company CoCode: 10677 State of Domicile: Ohio
 6200 S. Gilmore Road Group Code: 244 Company Type:
 Fairfield, OH 45014 Group Name: State ID Number:
 (513) 870-2000 ext. [Phone] FEIN Number: 31-0542366

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Cincinnati Insurance Company	\$50.00	10/03/2007	15931560

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	10/10/2007	10/10/2007

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Disposition

Disposition Date: 10/10/2007

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CNNA-125312421 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	PROPERTY AND CASUALTY TRANSMITTAL	Approved	Yes
Supporting Document	FORM FILING SCHEDULE	Approved	Yes
Supporting Document	MEMORANDUM	Approved	Yes
Form	PROFESSIONAL LIABILITY APPLICATION (PODIATRISTS)	Approved	Yes
Form	DENTIST'S PROFESSIONAL LIABILITY APPLICATION	Approved	Yes

SERFF Tracking Number: CNNA-125312421 State: Arkansas
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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	PROFESSIONAL LIABILITY APPLICATION (PODIATRISTS)	LC 10 70	08 07	Application/ Replaced Binder/Enrollment	Replaced Form #:0.00 LC-1070 (1/98) Previous Filing #: N/A		LC1070 08-07.pdf
Approved	DENTIST'S PROFESSIONAL LIABILITY APPLICATION	PA 007	07 07	Application/ Replaced Binder/Enrollment	Replaced Form #:0.00 PA-007 (12/05) Previous Filing #: CPRO-06-6011-AR		PA007 07-07.pdf

18. How many of the following support personnel are employed by you or your group?

- A. _____ Technicians D. _____ Medical Assistants G. _____ Acupuncture Technicians
- B. _____ Nurses (RN, LVN, LPN) E. _____ Physician Assistants H. _____ Other (Describe)
- C. _____ Nurse Anesthetists F. _____ Physiotherapists

19. Have you ever had your professional liability insurance declined, cancelled or renewal refused?
(This question is not applicable in Missouri.) No Yes

20. Have you ever had your professional liability insurance issued on a restrictive basis? No Yes

21. Have you ever had a claim / suit for alleged error, mistake or malpractice or are you aware of any incident
which may develop into a claim / suit? No Yes
If yes, explain: _____

22. a. Expiration date of present professional liability insurance: _____

b. Name of present insurance carrier: _____

c. How long have they written your insurance? _____

d. Have you ever been insured under a claims-made policy? No Yes

If yes, has extended reporting period coverage been purchased from previous carrier? No Yes

The foregoing answers / statements are complete and correct to the best of my knowledge and belief, If more space is needed, attach a separate sheet of paper with details.

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Applicant's Signature

Date

Agent's Signature

Date

Agency and Code Number

Agent's Name and License Number (Florida only)

NEW _____

RENEWAL OF POLICY NUMBER _____

ADD'L DENTIST TO POLICY NUMBER _____

DENTIST'S PROFESSIONAL LIABILITY APPLICATION



- 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 LLC LLP 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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) | <input type="checkbox"/> | <input type="checkbox"/> |

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 you received state or regional board certification: _____
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
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 or placed you on probation? Yes No
- b. Do you have any current hospital staff appointments or privileges? Yes No
- c. Have you had hospital privileges granted, denied or revised? Yes No
- d. Has your membership in a dental association ever been revoked or suspended? Yes No
- e. Do you perform any procedures which have been introduced to the practice of dentistry within the last two years? Yes No
- f. Have you ever had a case brought against you in peer review? Yes No
- g. Have you ever voluntarily surrendered or had a DEA license refused, suspended or revoked? Yes No

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. Indicate the percentage of time devoted to the following activities and check the techniques or procedures you perform. **Percentage must add up to 100%. Please do not list 100%**

General Dentistry.

_____ % Endodontics

Do you treat only single rooted teeth? Yes No

Do you treat multi-rooted teeth? Yes No

Do you use Sargenti paste / cement? Yes No

_____ % Pedodontics

_____ % Orthodontics

_____ % Periodontics:

Check Appropriate Procedures / Cases Treated

_____ 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)

_____ % Other, please describe (print or type): _____

- b. 1. Do you extract third molars? If yes,
 - (a) Erupted Yes No
 - (b) Impacted, soft tissue or partial bony Yes No
 - (c) Impacted, other than soft tissue or other than partial 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. Surgical implants Yes No If "Yes", complete Section VIII.
- d. 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.

7. Number of professional employees in the following categories:

_____ Hygienists _____ Dental Assistants _____ E.F.D.A.s _____ A.Q.P. _____ Anesthesiologists / Anesthetists

_____ Others, please describe: _____

_____ 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 (N2O)..... 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
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. What type of implants do you place?
 - a. Endosteal Yes No
 - b. Subperiosteal Yes No
 - c. Other (please describe): _____

5. How many implants have you placed over the past 24 months and how many implant patients did you treat during the same period? _____
6. How many patients do you estimate placing implants in over the next 24 months? _____
7. Attach copies of the informed consent form and patient education material you utilize prior to placing implants.
8. What criteria do you use in selecting patients for implants? _____

SECTION IX - SUPPLEMENTAL INFORMATION

CLAIM INFORMATION

1. Name of patient / claimant: _____ 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.

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Applicant's Signature

Date

Agent's Signature

Date

Agency and Code Number

Agent's Name and License Number (Florida only)

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Bypassed -Name: Uniform Transmittal Document-Property & Casualty
Bypass Reason: N/A
Comments:

Review Status: Approved 10/10/2007

Satisfied -Name: PROPERTY AND CASUALTY TRANSMITTAL
Comments: PROPERTY AND CASUALTY TRANSMITTAL
Attachment: F777AR_307.pdf

Review Status: Approved 10/10/2007

Satisfied -Name: FORM FILING SCHEDULE
Comments: FORM FILING SCHEDULE
Attachment: F778AR_307.pdf

Review Status: Approved 10/10/2007

Satisfied -Name: MEMORANDUM
Comments: MEMORANDUM
Attachment: MEMOF.pdf

Review Status: Approved 10/10/2007

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #	CPRO-07-6008-AR
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21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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See Memorandum

22. Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: EFT FILING

Amount: \$50

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do **not** refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	CPRO-07-6008-AR			
2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	N/A			
3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement or Withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	PROFESSIONAL LIABILITY APPLICATION (PODIATRISTS)	LC 10 70 08 07	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	LC 10 70 01 98	N/A
02	DENTIST'S PROFESSIONAL LIABILITY APPLICATION	PA 007 07 07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	PA 007 12 05	CPRO-06-6011-AR
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

**ARKANSAS
DIVISION SEVEN - PROFESSIONAL LIABILITY
FORMS MEMORANDUM**

NEW FORM	OLD FORM	TITLE/DESCRIPTION OF CHANGE
LC 10 70 08 07	LC-1070 (1/98)	<p>PROFESSIONAL LIABILITY APPLICATION (PODIATRISTS) Added additional limit options under item 3. Added items 5. and 6. Revised entity types under item 10. Listed procedures that are not considered surgery under item 15. Added space for listing surgical procedures under item 15. Deleted former item 25. regarding surgical procedures performed. Updated fraud warning.</p>
PA 007 07 07	PA-007 (12/05)	<p>DENTIST'S PROFESSIONAL LIABILITY APPLICATION</p> <p>Under Section I - General Information, added a spot to indicate the insured's website.</p> <p>Under Section IV - Coverage Information, added \$500,000/\$500,000 option.</p> <p>Under Section V - Practice Information, item 5., added a question regarding mini or immediate load implants. Deleted the questions regarding laser surgery.</p>